Parkway Endoscopy Center _____

Patient & Insurance Information Record

Patient Information

Last Name: _____ First: _____ MI: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

DOB: _____ Marital Status: _____ Male/Female: _____

Social Security #: _____ Race: _____ Ethnicity: _____

Emergency Contact Name: _____ Phone: _____

Employer Name: _____ Phone: _____

Employer Address: _____ State: _____ Zip: _____

Referring Physician: _____ Phone: _____

Responsible Party: _____ Phone: _____

Primary Insurance Information

Insurance Company: _____ Phone: _____

Policy #: _____ Group #: _____ Precert #: _____

Insured's Name: _____ Social Security #: _____

Insured's DOB: _____ Employer: _____

Claims Address: _____ State: _____ Zip: _____

Secondary Insurance Information

Insurance Company: _____ Phone: _____

Policy #: _____ Group #: _____ Precert #: _____

Insured's Name: _____ Social Security #: _____

Insured's DOB: _____ Employer: _____

Claims Address: _____ State: _____ Zip: _____

Patient/Guarantor Signature: _____