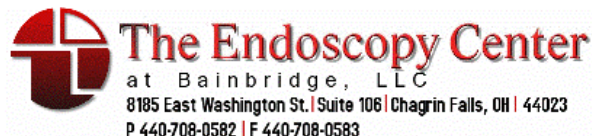


PATIENT REGISTRATION FORM



Patient Information

Patient Name: _____ Male Female

Address: _____
Street City State Zip

Mailing Address: _____
(if different from above)

Date of Birth: _____ Social Security #: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

Referring Physician: _____ Referring Physician Phone: _____

Insurance Information

Primary Policy Holder _____ Secondary Policy Holder (if applicable) _____

Date of Birth _____ Date of Birth _____

SSN of Primary Insured _____ SSN of Secondary Insured _____

Employer of Insured _____ Employer of Insured _____

Name of Primary Insurance _____ Name of Secondary Insurance _____

Effective Date _____ Effective Date _____

Group No. _____ Group No. _____

Emergency Contact

Name/Relationship: _____ Phone: _____

Release of Benefits and Information

I authorize my insurance benefits to be paid directly to The Endoscopy Center at Bainbridge. I understand that I am financially responsible for any balance due. I authorize The Endoscopy Center at Bainbridge or the insurance company to release any information for these claims.

Signature: _____ Date: _____

Name/Relationship of Driver: _____ Cell Phone: _____