Hanover Endoscopy Center

PLEASE COMPLETE ALL INFORMATION

PATIENT DEMOGRAPHIC FORM

PATIENT INFORMATION

PATIENT:______________________________ AGE:________ DATE OF BIRTH:________________

ADDRESS:______________________________ SOCIAL SECURITY #________________________

CITY__________________________________ HOME PHONE#: ___________________________

STATE______________ ZIP CODE:______________ WORK PHONE: ________________________

MOBILE/CELL PHONE #: ______________________ EMAIL ADDRESS:______________________

MARITAL STATUS : Please circle : M S D W FEMALE ________ MALE_________

REFERRING/FAMILY PHYSICIAN:____

DO YOU HAVE A LIVING WILL? YES NO WOULD YOU LIKE INFORMATION? YES NO

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY ___________________________ PHONE ____________________________

MEMBER# _____________________________________ GROUP# ___________________________

INSURED EMPLOYER: ___________________________ EMPLOYER PHONE #:__________________

NAME OF INSURED______________________________ INSURED SOCIAL SECURITY ___________

INSURED DATE OF BIRTH ________________________ RELATIONSHIP TO PATIENT___________

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY ___________________________ PHONE ____________________________

MEMBER # ____________________________________ GROUP#____________________________

INSURED EMPLOYER:____________________________ EMPLOYER PHONE #: _________________

NAME OF INSURED:_____________________________ INSURED SOCIAL SECURITY :__________

INSURED DATE OF BIRTH ________________________ RELATIONSHIP TO PATIENT___________

EMERGENCY CONTACT INFORMATION

CONTACT NAME:________________________________ PHONE #: _________________________

RELATIONSHIP:________________________________ ALTERNATE PHONE #:________________

RELEASE OF AUTHORIZATION/ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process my insurance claim(s). I authorize and request payment of medical benefits directly to my physicians. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I agree that I have provided accurate insurance information for services rendered at Hanover Endoscopy Center. I agree that a photocopy of this form may be used in place of the original.

______________________________________ ________/________/______

Signed (Patient or Representative) Date

PLEASE COMPLETE & BRING WITH YOU TO HANOVER ENDOSCOPY CENTER ON DATE OF APPOINTMENT.