



# Colon & Rectal Specialists, Ltd.



## PATIENT REGISTRATION

### PATIENT INFORMATION

Last Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ First Name \_\_\_\_\_  
 Telephone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Pager \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Social Security \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age \_\_\_\_\_  
 Marital Status \_\_\_\_\_ Sex \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
 Employer Telephone \_\_\_\_\_ Employer \_\_\_\_\_  
 Employer Address \_\_\_\_\_

### EMERGENCY CONTACT INFORMATION

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
 Telephone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Pager \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Employer \_\_\_\_\_ Employer Telephone \_\_\_\_\_

### PHYSICIAN INFORMATION

Primary Care Physician \_\_\_\_\_ Do you want a report sent? \_\_\_\_\_  
 Referring Physician \_\_\_\_\_ Do you want a report sent? \_\_\_\_\_

### INSURANCE INFORMATION

Primary Insurance \_\_\_\_\_ Subscriber's Name \_\_\_\_\_  
 Insurance Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Patient's Relationship to Subscriber \_\_\_\_\_  
 Subscriber's Employer \_\_\_\_\_ Subscriber's date of birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Subscriber's Social Security # \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Subscriber's Name \_\_\_\_\_  
 Insurance Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Patient's Relationship to Subscriber \_\_\_\_\_  
 Subscriber's Employer \_\_\_\_\_ Subscriber's date of birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Subscriber's Social Security # \_\_\_\_\_

I authorize direct payment to Colon & Rectal Specialists, Ltd. from the above insurance companies (if any) and any unpaid balance will be paid by me. If payment for services is not made when due, I agree to pay all cost of collection including, but not limited to, attorneys fees in the amount of 33 1/3% of the delinquent amount owed. This is a lifetime authorization.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

For office use only	Physician		Patient Acct#		New		Date
					Update		Date