PATIENT REGISTRATION

WELCOME TO SANTA CRUZ ENDOSCOPY CENTER! Please complete this form in full, leaving no blanks. If anything does not apply, please indicate so. Then read and sign the last portion.

Please Print Clearly

J. Bennet G. Lee Z. Majuk L. Miller

Patient Name_____ Today's Date_____

Birthdate____/____/____ Age_____ Social Security Number_____

Please circle: Single Married Divorced Widowed

Please circle: Male Female

Home Phone ( )_____-_____

Work Phone ( )_____-_____ Ext._____

Cell Phone ( )_____-_____

Home Address_____
Street number and name – please remember apartment number if needed

_____
City State ZIP

Your employer_____ Your Occupation_____

Spouse Name_____ Spouse Birth Date_____

Spouse Employer_____ Spouse Work Phone( )_____-_____

Name of Referring Doctor or Primary Care Physician_____

If not referred by a Doctor, then how did you hear about our office? (circle) friend yellow pages web page Insurance book

Name and Phone Number of Friend or Relative not living with you that we may contact in case of emergency

_____
Name Relation Phone

Is this new insurance? (circle) No Yes Effective Date_____/_____/_____

Primary Insurance Company _____ Subscriber (circle) Self Spouse Parent

Billing Address _____
Address City, State, ZIP

I.D. Number _____ Group Number_____

Secondary Insurance Company _____ Subscriber (circle) Self Spouse Parent

Billing Address _____
Address City, State, ZIP

I.D. Number _____ Group Number_____

I, the undersigned, understand the payment policies of this office and understand that I am financially responsible to the treating physician for all charges incurred regardless of insurance coverage. If the amount due is not paid, I agree to bear collection costs, court costs, and legal fees.

Signature of Responsible Party_____ Date_____