

PREREGISTRATION DATA FORM

Please fill out this form and bring with you to the appointment.
PLEASE WRITE LEGIBLY SO WE GET THE INFORMATION CORRECT
FILL IN ALL BLANKS!

Date of appointment: _____ GI Physician to see _____

Patients Last Name _____ First _____ Middle _____

Date of Birth _____ Sex: *M / F* Race _____

Address _____

City _____ County _____ State _____ Zip _____

Home Phone (_____) _____ Patients SS# _____

Parents First and Last Name _____

Guarantor (Person who has insurance for child; medicaid or no insurance, fill in information for parent.)

Last Name _____ First _____ Middle _____

Relationship to Patient _____ Sex - *M / F*

Social Security # _____ Date of Birth _____

Address (if different from child) _____

City _____ State _____ Zip _____

Home Phone(_____) _____ Work Phone(_____) _____

Guarantors Place of Employment: _____

Address _____

Occupation _____ Full time or Part time _____

Primary contact information (if other than guarantor)

Last Name _____ First _____ Middle _____

Address if different _____

City _____ State _____ Zip _____

Phone: Home(_____) _____ Work (_____) _____

Relationship to Patient _____

Emergency contact information

Last Name _____ First _____ Middle _____

Date of Birth _____ Address _____

Phone _____ Relationship _____

If Medicaid - what is Medicaid number for patient _____

Insurance Company: GIVE ALL INFORMATION ON CARD EVEN IF WE DON'T ASK ABOUT IT

Ins Co. Full Name _____

Is this a PPO / PPN/ HMO/ MC? Or give any other initials listed _____

Any NETWORK listed? _____

Policy/ ID or SS # Number _____

Plan Name _____ Group Name and/or Number _____

Employee's Full Name (as it is on Card) _____

Mail Claims to: (give name and address) _____

Precertifications Phone # _____

SECONDARY INSURANCE: IF YOU HAVE MORE THAN 1 INSURANCE, GIVE SAME INFORMATION NEEDED ABOVE PLUS DATE OF BIRTH AND SS# OF MEMBER IN THIS PROVIDED SPACE.

If you have a copy of your insurance card to send too, that would be very helpful.

Referring Doctor Information:

Last name _____ First Name _____

Address _____

City _____ State _____ Phone(_____) _____

Is this you Primary Care Physician Y / N If not write his/her name, address, phone below.

Why are you being seen in our clinic (Circle): Constipation? Diarrhea? Vomiting? Abdominal Pain?

Poor Weight Gain? Other: (write in) _____