# CLINIC FOR COLON & RECTAL SURGERY, P.A.

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***PLEASE PRINT***

Name: _____ Date of Birth: _____ Sex: M or F

Social Security Number: _____ Marital Status: _____ Religion: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Number: ( _____ ) _____ Work: ( _____ ) _____ Cell: ( _____ ) _____

Primary Number: Home Work Cell Preferred Appointment Reminder: Phone Text Email

Email Address: _____

Place of Employment: _____

Hispanic or Latino: Yes or No Primary Language: _____ Primary Communications: Phone Mail

Spouse / Parent Name: _____ Spouse / Parent Date of Birth: _____

Spouse / Parent Employer: _____ Business Phone: ( _____ ) _____

Social Security Number: _____ Cell Phone: ( _____ ) _____

Emergency Contact (Outside of the Home): _____ Phone: ( _____ ) _____

What physician referred you to us? Dr. _____

Have you seen any of our doctors before? _____ If so, who _____

Primary Insurance Company: _____ Contract #: _____ Group #: _____

Subscriber Name: _____ Relation: _____

Secondary Insurance Company: _____ Contract #: _____ Group #: _____

Subscriber Name: _____ Relation: _____

**PATIENT'S OR AUTHORIZED SIGNATURE**

I authorize the release of medical information necessary to process any insurance claim on my behalf. A copy of this authorization shall be considered as valid as the original.

**SIGN:** _____ **Date:** _____

I authorize payment to the Clinic for Colon & Rectal Surgery of benefits otherwise payable to me. I understand that I am financially responsible to those indicated above for charges not covered by this authorization. I also agree that, should I not assume this financial responsibility if any credit action is necessary, I will pay for those costs in addition to the amount of the doctor's charge.

**SIGN:** _____ **Date:** _____