

GLEN ENDOSCOPY CENTER, LLC

DEMOGRAPHICS

Name: Mr/Mrs/Ms. _____
 Address: _____ City: _____ State: _____ Zip: _____
 Social Security Number: _____ Date of Birth: _____
 Home Phone: (____) _____ Cell Phone: (____) _____ Business Phone: (____) _____

ETHNICITY (Please Circle) Hispanic or Latino Non Hispanic or Latino

Race (Please Circle) American Indian or Alaska Native Asian Black or African American
 Native Hawaiian or Pacific Islander White Other: _____

Employer: _____ Occupation: _____
 Employer's Address: _____
 Marital Status: _____ Spouse's Name: _____
 Address: _____ Phone: _____
 In case of Emergency Contact: _____ Relation of Emergency Contact: _____
 Home Phone: _____ Cell Phone: _____ Business Phone: _____
 Referring Physician: _____

MEDICAL INSURANCE INFORMATION

Primary Insurance Company: _____ Telephone Number: _____
 Policy Number: _____
 Group Number: _____ Policy Holder: _____
 Your relationship to the policy holder: _____ Policy Holder Date of Birth: _____

Secondary Insurance Company: _____ Telephone Number: _____
 Policy Number: _____
 Group Number: _____ Policy Holder: _____
 Your relationship to the policy holder: _____ Policy Holder Date of Birth: _____

RESPONSIBLE PARTY (If other than patient)

Name: Mr/Mrs/Ms. _____
 Address: _____ City: _____ State: _____ Zip: _____
 Social Security Number: _____ Date of Birth: _____
 Home Phone: (____) _____ Business Phone: (____) _____
 Employer: _____ Occupation: _____
 Responsible party/Guarantor's Signature: _____

"I have reviewed the above information and all is current and accurate."

Signature **Date**

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize the release of any medical information necessary to process my health insurance claims and request payment of benefits to the Glen Endoscopy Center where services were provided. I permit a copy of this authorization to be used in place of the original. I understand that I am financially responsible to the center for charges not covered or denied by my insurance company. I further agree in the event of my non-payment, to pay the cost of collection and/or court costs and reasonable fees should this be required.

Signature **Date**