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***