

COLON & RECTAL ASSOCIATES
Registration Form

Patient Name: : First _____ Middle _____ LAST _____
Address : _____
City, State, Zip : _____
Date of Birth : _____
Social Security # : _____
Sex : [] Female [] Male
Marital Status : [] Single [] Married [] Divorced [] Widowed
Telephone : Home _____ Work _____ Cell _____
Employer : _____
Emergency Contact : _____
Emergency Phone : _____
PRIMARY INSURANCE: _____
2ND INSURANCE : _____

Please have ALL insurance card(s) and one photo ID available when at registration for copying

SPOUSE

Name: _____ SS# : _____
Employer: _____ Work Phone: _____

Payment for office services is due on the day of service. If you have a co-pay, this must be paid prior to seeing the doctor. As part of our service we will submit your insurance claims. Insurance/Financial arrangements should be made prior to procedures/surgeries.

RELEASE OF INFORMATION AND ASSIGNMENTS OF BENEFITS DECLARATION

I hereby authorize release of any medical information necessary to process my insurance claim and also ASSIGN to the DOCTOR all payments from my insurance plan(s) for services rendered. I understand and agree to the above.

Date

Signature