Colorectal Health Northwest

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Colon and Rectal Surgeons
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PATIENT INFORMATION

Today's Date:_____ Referring Physician: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Sex: M ____ F____

Email address: _____ Primary Language_____ Ethnicity: _____ Race: _____

Home Phone: _____ Cell Phone: _____ Age: _____

Date of Birth: _____ Married: _____ Single: _____ Divorced: _____ Domestic Partner: _____ Widowed: _____

Patient Employer: _____ Work phone: _____

Employer Address: _____

City: _____ State: _____ Zip Code: _____ Occupation: _____

Emergency Contact: _____ Relationship_____ Phone: _____

Primary Insurance

Insurance Name: _____ Co-payment:$ _____

Policy Holder/Subscriber Name: _____ Relationship: _____ DOB: _____

Insurance Address: _____

City: _____ State: _____ Zip Code: _____

Insurance ID No. or Social Security #: _____ Group or Plan No.: _____

Secondary Insurance

Insurance Name: _____ Co-payment:$ _____

Policy Holder/Subscriber Name: _____ Relationship: _____ DOB: _____

Insurance Address: _____

City: _____ State: _____ Zip Code: _____

Insurance ID No. or Social Security #: _____ Group or Plan No.: _____

Responsible Party Person responsible for payment: (please circle) Self Spouse Father Mother Other

Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Responsible Party Employer: _____ Work phone: _____

Address: _____

I understand that I am personally responsible for all charges by my physician whether or not paid for by insurance and guarantee payment of the bill. I authorize payment of the medical benefits directly to the physician. I also authorize release of medical or other information to my insurance company.

Signature required: ***Date:***