Allied Digestive Health

Atlantic Coast Gastroenterology, Associates, LLC

Patient Registration Form

Please Complete All Information

Appointment Date: _____

Patient Information

Last Name: _____ First Name: _____ M.I.: _____

Date of Birth____/_____/____ Age: _____ SSN: _____-____-_____ Sex: M / F Marital Status: S M D W

Race: _____ Ethnicity: _____ Pref. Language_____

Address: _____ City: _____ State: _____ Zip Code: _____

Email: _____ Home Phone: _____ Cell Phone: _____

Employer: _____ Emp. Address: _____ Emp. Phone: _____

Primary Care Physician: _____ Referring Physician: _____

Pharmacy Name: _____ Pharmacy Address: _____

Pharmacy Phone: _____ Rx Card Number: _____

Emergency Contact: _____ **Relationship to Patient:** _____

Emergency Contact Primary Phone: _____ Secondary Phone: _____

Primary Insurance **Please provide a copy of insurance card.**

Insurance Carrier: _____ Policy ID # _____ Group # _____

Insurance Effective Date: _____/_____/_____ Insurance Co Phone _____

Insurance Address: _____

Subscriber's Name: _____ Relationship to Patient: _____

Address if different from patient: _____ City: _____ State: _____ Zip Code: _____

Subscriber's Phone # _____ Subscriber's Date of Birth: _____/_____/_____ SSN:_____-_____-____

Subscriber's Employer _____

Secondary Insurance **Please provide a copy of insurance card.**

Insurance Carrier: _____ Policy ID # _____ Group # _____

Insurance Effective Date: _____/_____/_____ Insurance Co Phone _____

Insurance Address: _____

Subscriber's Name: _____ Relationship to Patient: _____

Advance Directive: YES / NO **Power of Attorney:** YES / NO

Patient/Guardian Signature: _____ **Date:** _____