

## Patient Information

Your Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Gender: \_\_\_\_\_  
 (First) (MI) (Last)

Marital Status:  Single  Married  Divorced  Widowed  Separated  Other Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Phone: \_\_\_\_\_  H  W  C Secondary Phone: \_\_\_\_\_  H  W  C

May we text you appointment reminders?  Yes  No Email: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

## Optional Questions

Preferred Language: \_\_\_\_\_ Race:  American Indian/Native Alaskan  Black/African American

Asian  Native Hawaiian/Pacific Islander  White  Other Are you Hispanic/Latino?: \_\_\_\_\_

## Responsible Party Self

Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_  H  W  C

## Emergency Contact I authorize Arizona Digestive Health to release health information to my Emergency Contact

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

## Additional Information

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

How Did You Hear About Us?:  Friend/Family  Our Website  Primary Care Physician  Google/Search Engine Results

Social Media  Radio  Television  Magazine/Other Publication  Online Review/Rating Site

## Insurance Information

**Primary Insurance Company:** \_\_\_\_\_ Relation to Subscriber: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Subscriber SS#: \_\_\_\_\_

**Secondary Insurance Company:** \_\_\_\_\_ Relation to Subscriber: \_\_\_\_\_

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Subscriber SS#: \_\_\_\_\_

I assign all medical/surgical benefits to Arizona Digestive Health, P.C. and understand that I am financially responsible for all charges whether or not they are paid by insurance. I authorize payment to be made to the provider. In the event that the payment is made to the policyholder, I agree to submit payment in full to this office immediately. If the account is not paid in full, and prior arrangements have not been made, your account(s) may be referred to a collection agency. If your account is referred to an agency, you will be responsible for all attorney's and/or collection fees.

I hereby authorize the doctor to release or procure all information necessary to secure the payments of benefits, for treatment purposes, or to another health care provider or destination at my discretion. I may revoke this authorization at any time in writing, with the exception of insurance disclosures for billing purposes. I consent to communicate via electronic means for routine matters. I further agree that a photocopy of this agreement shall be as valid as the original. I certify the above information is true and correct to the best of my knowledge. I understand that HIPAA and privacy policies are available online and in the office by request.

I have read and understand the information on this form.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date