WELCOME TO CAPE FEAR CENTER FOR DIGESTIVE DISEASES, P.A.

Please assist us by completing the Patient Registration Form. The information is necessary for our files and will be considered confidential.

GENERAL PATIENT INFORMATION: REQUESTING PHYSICIAN _____

_____ _____ _____
Patient's Last Name First Name Middle Initial

_____
Street Address

_____ _____ _____ _____
City State Zip Social Security Number

_____ _____ _____ _____
Home Phone Number Cell Phone Number Work Phone Number Email Address

_____ Sex: M _____ F _____ Marital Status: circle Single …. Married …. Divorced …. Widowed …. Other _____
Date of Birth

Ethnicity: Please circle – Hispanic or Latino Not Hispanic or Latino

Race: (Please circle) White…. Black/African American…. Hispanic or Latino…. Asian…. Pacific Islander…. American Indian…. Other_____

_____ _____
Employed by Occupation

_____
Employer's Address

_____ _____ _____
Name of Person(s) to Notify in Case of Emergency Relationship to Patient Emergency Phone Number (other than numbers above)

INSURANCE INFORMATION:

_____
Primary Insurance Company

_____ _____
Address Group/Local Number

_____ _____ _____
Subscriber's Name Subscriber's Social Security Number Date of Birth

_____
Subscriber's Employer's Name

_____ Your Relationship to Subscriber: _____ _____ _____
Subscriber's ID Number Self Spouse Other

_____
Secondary Insurance Company

_____ _____
Address Group/Local Number

_____ _____ _____
Subscriber's Name Subscriber's Social Security Number Date of Birth

_____
Subscriber's Employer's Name

_____ Your Relationship to Subscriber: _____ _____ _____
Subscriber's ID Number Self Spouse Other

Insurance Assignment – Assignment of Insurance Benefits
I hereby authorize and request my insurance company to pay directly to the doctor the amount(s) due on my claim for services rendered to me or my dependent. I further agree that should the amount be insufficient to cover the entire medical and surgical expense. I will be responsible for payment of the difference; and if the nature of the disability be such that it is not covered by the policy, I will be responsible to the doctor for payment of the entire bill. I authorize the release of any medical information necessary for (TPO), treatment, payment and healthcare operations.

Patient's Signature _____ Date _____

Insured's Signature _____ Date _____