COLORECTAL WELLNESS CENTER

Please review and Complete the information below to the best of your ability.

Patient Registration

CURRENT PATIENT INFORMATION -- PLEASE PRINT

Last Name:

First Name:

Middle Name:

Address:

City: State:

Zip:

Home Phone:

Work Phone:

Mobile Phone:

Sex:

Date of Birth:

Social Security No.:

Patient email:

Required by government mandate [although you may refuse]:

Language:

Race:

Ethnicity:

Marital Status:

Guarantor Information (to whom financial statements are sent)

Name:

Address:

Relationship to patient: _____

Date of Birth:

Social Security No.:

Phone: ( ) _____ - _____

Emergency Contact Information

Name:

Relationship:

Phone:

Mobile Phone:( ) _____ - _____

Employer information

Employer:

Address:

Phone:

Other

Patient Referred by:

Primary Care Provider:

Contact Preference: Home Phone / Work Phone / Mobile Phone / Portal / Email

Pharmacy Information:

Name:

Crossroads:

Phone:

Primary Insurance Information	Secondary Insurance Information
Insurance Plan Name:	Insurance Plan Name:
Last Name:	Last Name:
First Name:	First Name.:
Middle Name:	Middle Name:
Address:	Address:
City:	City:
State: Zip:	State: Zip:
Date of Birth:	Date of Birth:
Sex (please circle): **M** or **F**	Sex (please circle): **M** or **F**
Employer Name:	Employer Name:
Patient's relationship to policy holder	Patient's relationship to policy holder

To the best of my knowledge the above information is complete and accurate.

Signed_____ **Date:**_____

Please sign and date each item below

ACKNOWLEDGEMENT AND AUTHORIZATION:

- **I have read and understand the HIPAA/Privacy Policy for Colorectal Wellness Center**

Signed_____ **Date:**_____

- **I hereby assign my insurance benefits to be paid directly to the healthcare provider**

Signed_____ **Date:**_____

- **I authorize Colorectal Wellness Center to release medical information required to process my claim**

Signed_____ **Date:**_____

- **I have read and understand the Financial Policy for Colorectal Wellness Center**

Signed_____ **Date:**_____

- **I authorize Colorectal Wellness Center to obtain/have access to my medication history**

Signed_____ **Date:**_____

- **I authorize my provider's office to contact me by mobile phone**

Signed_____ **Date:**_____