COLON & RECTAL SPECIALISTS, LTD.
PATIENT REGISTRATION FORM

Patient Information

Last Name ____________________ Home Address ____________________
First Name ____________________ M.I. ______ ____________________
Date of Birth __________ Age ______ Sex ______ City ____________________
Social Security No ____________________ ☐ Declined State ____________ Zip ________
Home Phone ____________________ Mobile Phone ____________________
Email Address ____________________ ☐ Declined Marital Status ________

Note: By providing your email address, you consent to be added to our patient portal.

Preferred Contact Method: ☐ Home Phone ☐ Mobile Phone ☐ Work Phone ☐ Snail Mail ☐ Patient Portal

Race ____________ ☐ Declined Ethnicity ____________ ☐ Declined Language ____________ ☐ Declined

Employment Information

Employer Name ____________________ Address ____________________
Phone ____________________ City ____________ State ________ Zip ________

Emergency Contact Information

Name ____________________ Relationship ____________________
Home Phone ____________________ Mobile Phone ____________________

Referral Source

Primary Care Physician ____________________ Referring Physician ____________________

New Patient Only – Please place a check mark next to applicable referral source: ☐ Referring Physician Noted Above

☐ Family Member/Friend ☐ Yellow Pages ☐ Newspaper/Magazine ☐ Internet ☐ Other ____________

Health Insurance Information

Primary Insurance ____________________ Mailing Address ____________________
Policy Identification Number ____________________ City ____________________
Policy Group Number ____________________ State ____________ Zip ________
Subscriber's Name ____________________ Subscriber's Social Security No ____________________
Subscriber's Date of Birth ____________________ Subscriber's Employer ____________________
Patient's Relationship to Subscribe ____________________

Secondary Insurance ____________________ Mailing Address ____________________
Policy Identification Number ____________________ City ____________________
Policy Group Number ____________________ State ____________ Zip ________
Subscriber's Name ____________________ Subscriber's Social Security No ____________________
Subscriber's Date of Birth ____________________ Subscriber's Employer ____________________
Patient's Relationship to Subscribe ____________________

I authorize direct payment to Colon & Rectal Specialists, Ltd., from the above insurance companies (if any) and any unpaid balance will be paid by me. If payment for services is not made when due, I agree to pay all costs of collection including, but not limited to, attorney fees in the amount of 33 1/3% of the delinquent amount owed. This is a lifetime authorization.

Signature of Patient or Responsible Party ______________________________ Date ________________