PRIVACY SIGNATURE ON FILE

DATE: _____

MEADOWBROOK ENDOSCOPY CENTER

Patient Information Form *Please **print** all information in the spaces provided.*

Last Name _____ First Name _____ M.I._____

Home Address _____ Town: _____ Zip Code_____

Marital Status: Single:____ Married:____ Divorced:____ Widowed:_____ Occupation: _____

Home Phone :( ) _____ Work Phone :( )_____ Cell Phone: ( ) _____

Employer Name and Address _____

Social Security Number:_____-_____-_____ Date of Birth: _____ Primary Care Doctor:_____

Race/Ethnicity: White___ Hispanic ___Asian ___European ___African American ___ Other____ Preferred Language_____

Name and Phone Number of person to contact in case of an emergency:

Name:_____ Phone#:_____ Relationship:_____

Advance Directive: Yes ▱ No ▱ Name of Health Care Proxy:_____

Primary Insurance

Company Name and Phone Number_____

Billing Address_____

Name of Insured and Relationship to Patient:_____DOB of Insured:_____

Insured's ID Number_____ Group Number_____

Secondary Insurance

Company Name and Phone Number_____

Billing Address_____

Name of Insured and Relationship to Patient_____ DOB of Insured:_____

Insured's ID Number_____ Group Number:_____

I hereby authorize payment of medical benefits billed to my insurance to **Meadowbrook Endoscopy Center and Meadowbrook Medical Associates.** I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees incurred by a collection agency.

I agree to pay all co-payments, coinsurance, and deductibles.

_____ _____

Signature of patient or guardian Date