

Personal Information	Mr./Mrs/Dr.			
	Miss/Ms.	Last Name	First	MI
Home Address	Street	City	State	ZIP
Email Address	*Check preferred contact number during business hours		<input type="checkbox"/> Home Phone: ()	
Social Security #	Date of Birth	Age	<input type="checkbox"/> Cell Phone: ()	
Occupation / Employer	Work Address		<input type="checkbox"/> Work Phone: ()	
Spouse's / Partner's Name	Employers Name		Their Phone: ()	
Emergency Contact: (Local relative or friend)	Address		Their Phone: ()	
Nearest Relative (relationship)	Address		Their Phone: ()	

REFERRED BY: _____ WHO IS YOUR PRIMARY CARE PHYSICIAN? _____

Insurance	PLEASE LIST ALL HEALTH CARE INSURANCE COMPANIES WHICH COVER THIS PATIENT:			
	PRIMARY:	Insurance Name _____	Ins Address _____	
	Holder's Name _____	Holder's ID _____	Date of Birth _____	Social Security # _____
	SECONDARY:	Insurance Name _____	Ins Address _____	
	Holder's Name _____	Holder's ID _____	Date of Birth _____	Social Security # _____

Responsible Party	Mr./Mrs/Dr.			
	Miss/Ms.	Last Name	First	MI
Address				Home Phone: ()
Occupation	Employers Name & Address		Work Phone: ()	

Assignment of Benefits * Financial Agreement

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor/ambulatory surgery center and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amounts, co-pays, co-insurance, or any other balance not paid for you by your insurance.

I directly assign all medical / surgical benefits to Digestive Health Center of Arizona, P.C. – Phoenix Endoscopy, L.L.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. In the event that 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 all information necessary to secure the payments of benefits. I further agree that a photocopy of this agreement shall be as valid as the original. I have read and understand the information on this form. I certify the information is true and correct to the best of my knowledge.

Date: _____ Your Signature: _____