Digestive HealthCare Center, PA

511 Courtyard Drive, Building 500, Hillsborough, NJ 08844
(908) 218-9222 Fax (908) 218-9818

Patient Information

***In order for us to file your insurance, the following form must be completed.**

PATIENT'S PERSONAL INFORMATION Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Name:________________________________ ________________________________ ____________
Last Name First Name Initial

Birthdate:______________________ SS#:__________________________ Male: ____ Female: ____

Street Address:____________________ (Apt.# ______) City:______________________________

State: ____________ Zip: ____________ Home Phone: (___)______________________________

Cell # (___)________________________ Work Phone: (___)______________________________

Email Address:____

Employer's Name & Address:____

Employer's Phone: (___)_________________________ Your Occupation:________________________

Spouse's Name:____________________________ ____________________________ ____________
Last Name First Name Initial

Spouse Birthdate:________________________ Spouse SS#:______________________________

PATIENT'S INSURANCE INFORMATION **SELF PAY (No insurance)** ☐

Primary Insurance Company Name:____

Policyholder Name:__________________________ Policyholder Birthdate:_______________________

Relationship to Patient: ☐ Self ☐ Spouse ☐ Other ID#:________________ Group #:________________

Secondary Insurance Company Name:____

Policyholder Name:__________________________ Policyholder Birthdate:_______________________

Relationship to Patient: ☐ Self ☐ Spouse ☐ Other ID#:________________ Group #:________________

PATIENT'S REFERRAL INFORMATION Primary Care Dr./Referring Doctor:_______________________

Address:___________________________________ Phone: (___)___________________________

Pharmacy Name: _____________________________ Pharmacy Phone: (___)__________________

Pharmacy Address:____

EMERGENCY CONTACT

Name of person NOT living with you:______________________ Relationship:__________________

Street Address:________________________ (Apt. #_____) City:______________________________

State________________________________ Zip Code____________________________________

Home Phone: (___)_________________________ Work or Cell # (___)__________________________

Should inaccurate or omitted insurance information be supplied causing a reduction or non-payment of benefits, the obligation of payment will be transferred to the responsible party. I hereby authorize the release of any medical information necessary for the processing of insurance. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled to Digestive HealthCare Center. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Signature:____ Date:_______________________