COLON & RECTAL SURGERY ASSOCIATES
PATIENT INFORMATION

*"PLEASE PRINT" and fill in **ALL** spaces* **ACCOUNT#**

PATIENT NAME: _____ DATE: _____

ADDRESS: _____CITY_____ STATE _____ ZIP _____

BEST *DAYTIME* PH# ( ) _____ - _____ HOME# ( ) _____ - _____ CELL# ( ) _____ - _____

E-Mail address: _____ (for the patient portal)

DATE OF BIRTH ___/___/____AGE _____SEX_____ SS# _____MARITAL STATUS: M S W D

PLACE OF EMPLOYMENT_____ OCCUPATION_____ WORK# _____

SPOUSE NAME:_____ CELL#( ) _____ DATE OF BIRTH_____/____/_____

REFERRING DR. NAME:_____ PRIMARY DR. NAME: _____

PHARMACY NAME: _____ PH# or LOCATION _____

INSURANCE INFORMATION

IS INSURANCE IN **PATIENTS** NAME? ____YES____NO **IF NO, PLEASE LIST FOLLOWING INFORMATION:**

PRIMARY CARDHOLDER'S NAME: _____ EMPLOYER _____

SS# _____-_____-_____ DATE OF BIRTH _____/____/_____ EMPLOYER PHONE( )_____

HIPAA INFORMATION

List spouse, relatives (&/or) friends we may release your medical information to.

Name: _____ Relationship: _____ Phone # ( )_____

Name: _____ Relationship: _____ Phone # ( )_____

_____ (READ & INITIAL). IT IS OUR OFFICE POLICY THAT YOUR CO-PAY, DEDUCTIBLE &/OR CO-INSURANCE BE PAID AT EACH OFFICE VISIT. IF SURGERY/PROCEDURE IS SCHEDULED WE REQUEST ANY DEDUCTIBLE &/OR CO-INSURANCE BE PAID **BEFORE** THE SURGERY/PROCEDURE. YOU ARE ALSO RESPONSIBLE FOR ANY BALANCES NOT PAID/COVERED BY YOUR INSURANCE COMPANY.

THIS OFFICE DOES NOT ACCEPT MEDICAID

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans to:
JEFFREY GRIFFIN, M.D., HILDRETH McCARTHY, M.D., SEAN MAYFIELD, M.D., JENNIFER SILINSKY, M.D.
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. I hereby authorize said assignee to release all information necessary to secure the payment.

_____ _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE