PATIENT REGISTRATION

Thank you for choosing to use ColonoscopyDR.com to save money on your colonoscopy. Please fill out the following form in its entirety and take it with you when you visit the doctor for your procedure. Please print. All information will be confidential.

DATE:_____ PATIENT NAME:_____

SOCIAL SECURITY NUMBER (LAST FOUR DIGITS):_____

DATE OF BIRTH:_____ SEX: MALE FEMALE

MARITAL STATUS: SINGLE MARRIED WIDOWED SEPARATED DIVORCED

HOME ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

HOME PHONE:_____ MOBILE PHONE:_____

MAILING ADDRESS (IF DIFFERENT):_____

CITY:_____ STATE:_____ ZIP:_____

EMERGENCY CONTACT

Nearest friend or relative not living with you

NAME:_____ PHONE:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

ADVANCED DIRECTIVES/LIVING WILL

DO YOU HAVE ADVANCED DIRECTIVES? YES NO

PRIMARY CARE DOCTOR:_____

PHONE:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

PHARMACY:_____ PHONE:_____

ASSIGNMENT OF BENEFITS/AUTHORIZATION FOR TREATMENT

I hearby authorize treatment and authorize the provider of medical services to release any information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I further authorize payment of insurance benefits otherwise payable to me directly to the provider of the services. A copy of this signature is as valid as the original. I understand that I am financially responsible for all charges not covered by my insurance.

X_____ _____

SIGNATURE OF PATIENT DATE

INSTRUCTIONS

Once you have completed this form you may fax it or scan and email it to ColonoscopyDR.com.

EMAIL: forms@colonoscopydr.com

FAX: (727) 255-5314

Make your $300 payment at http://colonoscopydr.com/payment. The remaining balance will be due upon your doctor visit.

If you have any questions, please email info@colonoscopydr.com.