IRONWOOD
GASTROENTEROLOGY

Patient Registration

Patient Name (Last): _____ First: _____ Init: _____

Address: _____ Apt #: _____ City, State & Zip: _____

Home Phone: _____ Work Phone: _____ DOB: _____

Social Security #: _____ Male: ___ Female ___ Marital Status: M__ S__ D__ W__

Patient Employer: _____ Address: _____

Occupation: _____ Work Status: _____ Student Status: _____

Primary Care Physician: _____

Responsible Party Name: _____ Relationship to Patient: _____

Responsible Party Social Security #: _____ DOB: _____

How will the bill be paid today? _____

Emergency Contact: _____ Phone #: _____

Who referred you to the Ironwood Gastroenterology? _____

Do you have a living will? YES NO Would you like information on a living will? YES NO

Primary Insurance Company: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Relationship to Patient: _____ Employer: _____

Policy Number: _____ Group Number: _____

Co-Pay: _____ Deductible: _____

Effective Date of Coverage: _____

Secondary Insurance Company: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Relationship to Patient: _____ Employer: _____

Policy Number: _____ Group Number: _____

Effective Date of Coverage: _____

I certify that information provided pertaining to my health insurance coverage is true and correct. I authorize that payment for services rendered should be made payable to Ironwood Gastroenterology. I authorize Ironwood Gastroenterology release of medical information necessary to process this (these) claim(s). I have read all the terms and conditions contained in this agreement and to be bound by these terms and conditions.

Signature: _____ Date: _____