

SALEEBY AND WESSELS PROCTOLOGY PATIENT REGISTRATION FORM

Please print clearly

Name _____ SS# _____
First Middle Last Suffix

Birth Date _____ Age _____ Marital Status: Single, Married, Divorced, Widowed

Home Address _____
Street City State Zip

Home Phone () _____ Cell Phone () _____ Work Phone () _____

Occupation _____ Employer _____

Work Address _____
Street City State Zip

Spouse's Name _____ SS# _____

Spouse's Employer _____ Spouse's Birth Date _____

Spouse's Cell Phone () _____ Spouse's Work Phone () _____

NOTIFY IN CASE OF AN EMERGENCY

Name _____ Relationship _____

Home Address _____
Street City State Zip

Home Phone () _____ Cell Phone () _____ Work Phone () _____

Do you have health insurance? Yes No

Primary Insurance Company _____

Policy Holder/Responsible Party Name _____ Relationship to Patient _____

Policy Holder/Responsible Party SS# _____ Policy Holder Birth Date _____

Policy Holder Home Address _____
Street City State Zip

Secondary Insurance Company _____ Policy Holder _____

Primary Care Physician _____

How did you hear about our practice? _____

I certify that the information provided above is correct and complete to the best of my knowledge. I understand that all insurance information must be provided prior to services rendered. Furthermore, incomplete or incorrect information may result in claim denial or incomplete payment, which I would be financially responsible for.

Signature of Patient or Guardian

Date