ARIZONA DIGESTIVE HEALTH
powered by GI Alliance

Patient Registration Form

Patient Information

Your Name: _____ Birth Date: _____ Gender: _____
(First) (MI) (Last)

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Other Social Security #: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: _____ ○ H ○ W ○ C Secondary Phone: _____ ○ H ○ W ○ C

May we text you appointment reminders? ☐ Yes ☐ No Email: _____

Referring Physician: _____ Primary Care Physician: _____

Optional Questions

Preferred Language: _____ Race: ☐ American Indian/Native Alaskan ☐ Black/African American

☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other Are you Hispanic/Latino?: _____

Responsible Party ☐ Self

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____ ○ H ○ W ○ C

Emergency Contact ☐ I authorize Arizona Digestive Health to release health information to my Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Additional Information

Occupation: _____ Employer: _____

How Did You Hear About Us?: ☐ Friend/Family ☐ Our Website ☐ Primary Care Physician ☐ Google/Search Engine Results

☐ Social Media ☐ Radio ☐ Television ☐ Magazine/Other Publication ☐ Online Review/Rating Site

Insurance Information

Primary Insurance Company: _____ Relation to Subscriber: _____

ID #: _____ Group #: _____

Subscriber Name: _____ Birth Date: _____ Subscriber SS#: _____

Secondary Insurance Company: _____ Relation to Subscriber: _____

ID #: _____ Group #: _____

Subscriber Name: _____ Birth Date: _____ Subscriber SS#: _____

☐ I assign all medical/surgical benefits to Arizona Digestive Health, P.C. and understand that I am financially responsible for all charges whether or not they are paid by insurance. I authorize payment to be made to the provider. In the event that the payment is made to the policyholder, I agree to submit payment in full to this office immediately. If the account is not paid in full, and prior arrangements have not been made, your account(s) may be referred to a collection agency. If your account is referred to an agency, you will be responsible for all attorney's and/or collection fees.

☐ I hereby authorize the doctor to release or procure all information necessary to secure the payments of benefits, for treatment purposes, or to another health care provider or destination at my discretion. I may revoke this authorization at any time in writing, with the exception of insurance disclosures for billing purposes. I consent to communicate via electronic means for routine matters. I further agree that a photocopy of this agreement shall be as valid as the original. I certify the above information is true and correct to the best of my knowledge. I understand that HIPAA and privacy policies are available online and in the office by request.

☐ I have read and understand the information on this form.

_____ _____
Signature Date