HUNTSVILLE ENDOSCOPY CENTER

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PATIENT REGISTRATION

PLEASE COMPLETE (print, write, type, check, and/or select)　Social Security # ____________________________

Full Name: ____ Date of Birth: ____________________ Age: _____

Marital Status: ☐ Single ☐ Married ☐ Legally Separated ☐ Divorced ☐ Widowed　Sex: ☐ Male ☐ Female

Street Address: ____ City: ________________________ State:_______ Zip: ____________

Mailing Address: ______________________________________ City: ________________________ State:_______ Zip: ____________

Home Phone: __________________________ Cell Phone: __________________________ Work Phone: ______________________________

Employer: ____ May We Call You at Work? ☐ Yes ☐ No

Occupation:_________________________ Are You Self-Employed? ☐ Yes ☐ No　If Self, Name of Business: ________________________

Employer's Address: ____ How Long Employed? ____________ ☐ Full-Time ☐ Part-Time

Are You a Student? ☐ Yes ☐ No　☐ Full-Time ☐ Part-Time

Name of Spouse:_______________________________ Social Security #________________________ Date of Birth: ____________________

Spouse's Employer :____ Occupation: ______________________________

In Case of Emergency, Notify:____ Relationship: ______________________________

Home Phone: __________________________ Cell Phone: __________________________ Work Phone: ______________________________

Have You Seen Any of Our Doctors Before? ☐ Yes ☐ No　If Yes, Whom?____

Do You Have Medical Insurance Coverage? ☐ Yes ☐ No

Primary Insurance Company ____ I.D.# _______________________ Group: #:______________

Subscriber's Name ____ Relationship to Patient___________________________

Secondary Insurance Company ______________________________________ I.D.# _______________________ Group: #:______________

Subscriber's Name ____ Relationship to Patient___________________________

If You Have Medical Insurance Coverage, Please Give ALL of Your Cards to the Receptionist, Along With Any Completed Insurance Forms.

AUTHORIZATION & ASSIGNMENT: Please Read and Sign the Following Statement:

I directly assign all medical/surgical benefits to Huntsville Endoscopy Center and understand that I am financially responsible for all charges not covered by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

EXPRESS PRIOR CONSENT TO CONTACT CONSUMER BY CELL PHONE:

In the event that it becomes necessary to collect any amounts owed by you, you agree that Huntsville Endoscopy Center and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial messages and/or use of automatic dialing device, as applicable.

It is customary that payment be made when the service is rendered unless prior arrangements have been made in advance. In the event of non-payment, either by my insurance or myself, I agree to pay all costs of collection, including a reasonable attorney's fee in the event it is necessary to employ an attorney to enforce any provision of this contract. I/We further agree to waiver my/our rights of exemption under the laws of the State of Alabama or of any other state.

Signature: X ____ **Date:** X ________________________________

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