spokane digestive CENTER

PATIENT INFORMATION

PLEASE COMPLETE THIS FORM PRIOR TO ARRIVAL

Please bring this form, picture ID, insurance card and co-payment to your next appointment.

Date: _____

Patient's Legal Name: _____ Sex: ☐ M ☐ F
Last First M.I.

Birthdate: ____ / ____ / ____ Social Security Number: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Employer Name: _____ Work Phone: (____) _____

Primary Care Physician: _____ Referring Physician: _____

Language: ☐ English ☐ Spanish ☐ Russian ☐ other

Race: ☐ American Indian ☐ Native Hawaiian or other Pacific Islander ☐ Asian
☐ Caucasian ☐ Black or African American ☐ Hispanic or Latino ☐ Russian

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino

Primary Medical Insurance: _____

Policy # _____ Group # _____

Subscriber's Name: _____ Birthdate: ____ / ____ / ____

Subscriber's Employer: _____

Secondary Insurance (if any): _____

Policy # _____ Group # _____

Subscriber's Name: _____ Birthdate: ____ / ____ / ____

Subscriber's Employer: _____

Nearest friend/relative to contact in case of emergency, include alternate phone number(s)

Name: (Last) _____ (First) _____

Home Phone: (____) _____ Cell Phone: (____) _____

Relationship to Patient: _____

I authorize payment be made directly to Spokane Digestive Disease Center, P.S. of all insurance benefits otherwise payable to me for services rendered. I understand and acknowledge that I am financially responsible for all charges whether or not paid by insurance for services provided. I authorize Spokane Digestive and any provider or supplier of services in this practice to release any information required to secure payment of benefits. I authorize the use of this signature on all insurance claim submissions.

X _____

Signature of Patient or Authorized Person Date Relation, if not Patient