AFFILIATED ENDOSCOPY SERVICES OF CLIFTON

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PATIENT REGISTRATION

Patient's last name: First:		Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms	Date of Birth: / /
Street address:		Home phone no.: ( )			Cell phone no.: ( )
Email:	City:		State:		ZIP Code:
Social Security no.:	Patient Age;		Sex: ☐ Male ☐ Female		Marital Status:I ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Patient Employer:	Employer Address:	Employer phone no.: ( )
Patient Occupation:	Primary Care Physician:	Referring Physician (if different):

Spouse or Nearest Relative to You:	Address:	Phone no.: ( )	Relationship:

Responsible Person Name:	Address:	Social Security no.:	Relationship:
Employer and Address:		Home phone no.: ( )	Work phone no.: ( )

INSURANCE

Primary Carrier:	Subscriber:	Date of Birth: / /
Address:		
Policy ID:	Group #:	Plan #:

Secondary Carrier (if applicable):	Subscriber's name:	Group no.:	Policy no.:
Address:			
Policy ID:	Group #:	Plan #:	

I hereby authorized the above facility and anesthesiologist to release any information regarding services rendered by them and allow a photocopy of my signature to be used to file insurance. I also hereby authorize direct payment of benefits due for the services rendered by the above facility and anesthesiologist to be made directly to them regardless of my insurance benefits. Photocopies of this authorization shall be considered effective and valid as the original. I understand I am financially responsible for the fees for services rendered received and read the list of patient's rights.

Patient/Guardian signature *Date*