



Digestive Healthcare Consultants of Northwest Ohio

Adult Patient Registration

Date: _____ Referring Dr.: _____ Chart #: _____

Patient Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: ___/___/___ Social Security: ___-___-___ Ethnic Origin: _____ Male Female

Marital Status: Single Married Divorced Separated Maiden Name: _____

Street Address: _____ City: _____ State: ___ Zip: _____

Home Phone #: _____

Employer: _____ Work Phone #: _____

Employer Address: _____ City: _____ State: ___ Zip: _____

Nearest Relative Not Living With You:

Name: _____ Relationship: _____

Home Phone #: _____ Work Phone #: _____

Insurance Information

Primary Insurance Carrier: _____ Phone #: _____

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

Subscriber Name: _____ Relationship to Patient: _____

Subscriber Date of Birth: ___/___/___ Subscriber Social Security: ___-___-___

ID #: _____ Group #: _____ Employer Name: _____

Secondary Insurance Carrier: _____ Phone #: _____

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

Subscriber Name: _____ Relationship to Patient: _____

Subscriber Date of Birth: ___/___/___ Subscriber Social Security: ___-___-___

ID #: _____ Group #: _____ Employer Name: _____

Office Policy Agreement Acknowledgement:

My signature below indicates that I have received a copy of the Office Policy Agreement of Digestive Healthcare Consultants.

Patient Signature Date

Notice of Privacy Practices Acknowledgement:

I hereby acknowledge that I received a copy of the Notice of Privacy Practices of Digestive Healthcare Consultants. This Notice set forth the ways in which my personal health information may be used or disclosed by Digestive Healthcare Consultants, and outlines my rights with respect to such information.

Patient Signature Date

ASSIGNMENT OF BENEFITS / AUTHORIZATION FOR TREATMENT

I hereby authorize treatment and authorize the provider of medical service to release information regarding these services to my insurance carrier for payment. I further authorize that payments of benefits be made to the provider on my behalf. I understand that I am financially responsible for all charges not covered by my insurance carrier.

Patient Signature Date

DHC Staff Acknowledgement:

Employee Signature Date