DIGESTIVE HEALTH ASSOCIATES of Cheyenne

Today's Date: _____

Patient Name_____

Mailing Address _____ City _____ State _____ Zip _____

Telephone: Home _____ Work _____ Cell _____

Which phone would you like to be the primary number we call:_____

As a service to our clients, we provide a courtesy appointment reminder call that may be placed using a prerecorded message. By providing your cell phone number, you consent to receiving such calls at this number.

Email (for patient portal access): _____

Pharmacy: _____

Social Security # _____ Birth date _____

Marital Status: (Circle one) Single Married Divorced Widowed

Employer _____ Telephone _____

Authorized Parties to Speak with Regarding your Billing: Self Other_____

Insurance Information:

Primary Insurance _____
Name of Subscriber _____ Birth date _____ Social Security#_____

Secondary Insurance _____
Name of Subscriber _____Birth date_____Social Security#_____

EMERGENCY CONTACT INFORMATION:

Name _____ Relationship _____ Telephone _____

I hereby authorize medical treatment of the person named above and agree to be financially responsible for all charges for such treatment, including costs of collection and legal fees (if applicable.) I hereby assign payments to Digestive Health Associates. I authorize Digestive Health Associates to release any medical information necessary to process my insurance claims. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

Patient /Parent/ Guardian Signature: _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received a copy of Digestive Health Associates of Cheyenne.

Signature of Patient _____ Date_____