PATIENT REGISTRATION **SAN DIEGO ENDOSCOPY CENTER** **ACCT# ____________**

PLEASE PRINT

LEGAL NAME: ________________________________ MALE OR FEMALE HOME PHONE________________________

LAST FIRST MIDDLE MARITAL STATUS: M S OTHER CELL P HONE________________________

HOME ADDRESS:____
NUMBER STREET CITY STATE ZIP CODE

MAILING ADDRESS: ____
NUMBER STREET CITY STATE ZIP CODE

DATE OF BIRTH____________________AGE_______ SS #__________-__________-_________ DRIVERS LICENSE #______________________

EMPLOYER: ______________________________________PHONE # ______________________________

ADDRESS: ____OCCUPATION____________________

REFERRED BY
OR
PRIMARY CARE DR: ____

YOUR HUSBAND/WIFE/PARTNER: ______________________________SS# ______________________________

EMPLOYER: ______________________________________PHONE# ______________________________

ADDRESS: ______________________________________CELL# ______________________________

PLEASE PROVIDE COPY OF INSURANCE CARDS

PIMARY INSURANCE	SECONDARY INSURANCE
INS CO NAME ______________________	INS CO NAME______________________
ADDRESS______________________	ADDRESS______________________
______________________	______________________
______________________	______________________
POLICY#______________GROUP__________	POLICY # ______________GROUP__________

EMERGENCY CONTACT: ______________________________PHONE#______________________________
(NOT LIVING WITH YOU)
ADDRESS: ______________________________________RELATIONSHIP: ______________________

ASSIGNMENT OF BENEFITS**FINANCIAL AGREEMENT**

I hereby give authorization for payment of insurance benefits to be made directly to San Diego Endoscopy Center for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, collection fee of $85.00, and reasonable attorney's fees. I hereby authorize this healthcare provider 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.

SIGNATURE: ________________________________DATE: ______________________________