PATIENT REGISTRATION FORM
COLORECTAL SURGERY SERVICES, PLLC

19288 Stone Oak Parkway, Suite A San Antonio, TX 78258
Office: 210-490-2828 Fax: 210-490-0505

❑**New Patient** ❑**Established Patient** Account #: _____

PATIENT INFORMATION:

Patient's Last Name:_____First Name:_____MI:_____

Street Address:_____City_____State:_____ZIP:_____

Home Phone:_____Cell Phone:_____Work Phone:_____

Email Address:_____ Primary Language:_____

Sex: ❑ M ❑ F Marital Status: ❑Single ❑Married ❑Long-Term Partner ❑Divorced ❑Separated

Date of Birth:___/___/___ Driver's License #:_____State:____Social Security #:_____

Employer Name:_____Employer Phone:_____

Employer Street Address:_____City:_____State:_____ZIP:_____

Spouse Name:_____Date of Birth: ____/____/____ Social Security #:_____-_____-_____

Spouse's Employer Name:_____Spouse's Employer Phone:_____

Employer Street Address:_____City:_____State:_____ZIP:_____

Emergency contact:_____ Phone:_____

INSURANCE INFORMATION: A Copy of your Insurance Card(s) and Driver's License (photo ID) is Required

Primary Insurance:_____Phone:_____

Policy Holder Name:_____Policy ID:_____Group #:_____

Secondary Insurance:_____Phone:_____

Policy Holder Name:_____Policy ID:_____Group #:_____

COMMUNICATION AUTHORIZATION – Please Complete

We are committed to providing private and efficient communication with you. Please indicate the preferred method(s) of contact, should we need to reach you by phone. Place an "X" in the appropriate box (es).

❑Home ❑message to return **call** ❑ detailed message (results, treatment) ❑no message ❑voice mail ❑with individual
❑Work ❑message to return **call** ❑ detailed message (results, treatment) ❑no message ❑voice mail ❑with individual
❑Cell ❑message to return **call** ❑ detailed message (results, treatment) ❑no message ❑voice mail ❑with individual

In certain instances, it may be necessary to communicate via email: ❑ Yes - Email ❑No – Email

RELEASE OF INFORMATION POLICY – Please Read

I hereby authorize Colorectal Surgery Services, PLLC to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment, and other health care operations. My protected information may be released to the following individual(s):

Name:_____DOB:_____Relationship to Patient:_____

Name:_____DOB:_____Relationship to Patient:_____

Name:_____DOB:_____Relationship to Patient:_____

FINANCIAL POLICY – Please Read

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Colorectal Surgery Services or the insurance company to release any information required to process my claims.

NOTICE OF PRIVACY POLICIES – Please Read

I acknowledge that I have been provided the "Notice of Privacy Practices" for Colorectal Surgery Services, PLLC. I acknowledge that I have completed this form and certify that I am the patient or duly authorized to furnish the information requested.

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Signature of Patient or Responsible Party **Date**