

**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 #: \_\_\_\_\_

<b>PATIENT INFORMATION:</b>		
Patient's Last Name: _____	First Name: _____	MI: _____
Street Address: _____	City: _____	State: _____ ZIP: _____
Home Phone: _____	Cell Phone: _____	Work Phone: _____
Email Address: _____	Primary Language: _____	
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Long-Term Partner <input type="checkbox"/> Divorced <input type="checkbox"/> 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: _____	

<b>INSURANCE INFORMATION: A Copy of your Insurance Card(s) and Driver's License (photo ID) is Required</b>		
Primary Insurance: _____	Phone: _____	
Policy Holder Name: _____	Policy ID: _____	Group #: _____
Secondary Insurance: _____	Phone: _____	
Policy Holder Name: _____	Policy ID: _____	Group #: _____

<b>COMMUNICATION AUTHORIZATION – Please Complete</b>		
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).		
<input type="checkbox"/> Home	<input type="checkbox"/> message to return call	<input type="checkbox"/> detailed message (results, treatment)
<input type="checkbox"/> Work	<input type="checkbox"/> message to return call	<input type="checkbox"/> detailed message (results, treatment)
<input type="checkbox"/> Cell	<input type="checkbox"/> message to return call	<input type="checkbox"/> detailed message (results, treatment)
<input type="checkbox"/> no message	<input type="checkbox"/> voice mail	<input type="checkbox"/> with individual
<input type="checkbox"/> no message	<input type="checkbox"/> voice mail	<input type="checkbox"/> with individual
<input type="checkbox"/> no message	<input type="checkbox"/> voice mail	<input type="checkbox"/> with individual
In certain instances, it may be necessary to communicate via email: <input type="checkbox"/> Yes - Email <input type="checkbox"/> 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.

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date