

**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: <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: _____		

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).					
<input type="checkbox"/> Home	<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"/> Work	<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"/> 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
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