PATIENT INFORMATION FORM
Please Print

Patient Information:

Name: _____, _____ _____ Sex: ☐ M ☐ F
(Last) (First) (Middle)

Date of Birth: _____ Age: _____ Social Security #: _____

Local Address: _____ Apt/Unit/Space: _____

City: _____ State: _____ ZIP: _____ Phone _____

Alternate Address: _____ Apt/Unit/Space: _____

City: _____ State: _____ ZIP: _____ Phone _____

Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Widowed If Married, Name of Spouse: _____

Primary Care Physician: _____ Phone: _____

Emergency Contact:

Name: _____ Relationship: _____ Phone: _____

Additional Information:

Occupation: _____ Work Phone: _____

Employer: _____ Cell Phone: _____

How did you hear about us? ☐ Friend/Family ☐ Our Website ☐ Primary Care Physician ☐ Radio/Television
☐ Social Media ☐ Magazine/Other Publication ☐ Online Review/Rating Site

Optional Questions **(Questions asked to comply with Federal meaningful use requirements)**

Preferred Language: _____
Race: ☐ American Indian/Native American ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Pacific Islander
☐ White ☐ Two or More Races ☐ Other ☐ Unknown Are you Hispanic/Latino? _____

Insurance Information:

(1) PRIMARY INS. CO.: _____

Address: _____

Policy #: _____ Group # _____

Subscriber Name/Relationship to: _____ Subscriber DOB: _____

(2) SECONDARY INS. CO.: _____

Address: _____

Policy #: _____ Group # _____

Subscriber Name/Relationship to: _____ Subscriber DOB: _____

I have been offered a copy of the Notice of Privacy Practices from Digestive Disease Consultants, A Division of Arizona Digestive Health.

Date: _____ Signature: _____

IF YOU HAVE TWO INSURANCE COMPANIES, PLEASE PRESENT BOTH CARDS SO THAT WE MAY FILE WITH YOUR SECONDARY CARRIER FOR ANY BENEFITS DUE TO YOU.