

Desta Digestive Disease Medical Center

Name _____ Age _____ DOB: _____ Sex: _____ M _____

Address: _____ City: _____ Zip: _____

Home Phone(____) _____ Married _____ Single _____ Seperated _____ Widowed _____

Ethnic Background: _____ Driver's License # _____

Social Security # (Required) _____

Patient Employed By: _____ Business Phone: _____

Business Address: _____ City: _____ Zip: _____

Primary Care Physician: _____ Referred BY: _____

Emergency

Contact: _____ Relationship: _____ Phone: _____

Address: _____ City: _____ Zip: _____

INSURANCE INFORMATION (REQUIRED)

Primary Coverage, Name of Carrier:

Secondary Coverage, Name of Carrier:

Group No. _____

Group No. _____

ID Number _____

ID Number _____

Subscriber: _____

Subscriber: _____

Effective Date: _____

Effective Date: _____

Are you covered by Medicare? Yes No Medicare No. _____

Are you covered by Medi-Cal? Yes No Medi-Cal No. _____

Issue Date: _____

We ask all patients to show their insurance or manage care membership card at the time of service, so that we may make copies of them. We cannot render services on the assumption that our charges will be paid by an insurance company. All services are charged directly to the patient, and he or she remains personally responsible for payment. As a courtesy, however, we will prepare any necessary reports and itemizations to assist in making collections from insurance companies and will credit any such collections to the patient's account.

Payment Authorization:

I, _____, hereby authorize _____, MD, to furnish information concerning my present illness. I direct the insurer to pay without equivocation, directly to the physician, all benefits due him as a result of this claim. Although covered by insurance, I am aware that I am personally responsible for all charges. A photocopy of this authorization will be valid as the original.

Signature of Patient: _____ Date: _____

WOULD YOU LIKE INFORMATION ON ADVANCE DIRECTIVES? YES NO