EASTSIDE ENDOSCOPY CENTER

PATIENT REGISTRATION FORM

PLEASE BRING THIS COMPLETED FORM, INSURANCE CARD & PHOTO ID TO YOUR APPOINTMENT

Patient Information

Patient Legal Name: _____ ☐Male ☐Female

Address: _____
(Street) (City) (State) (Zip Code)

Billing Address: _____
If different from above (Street) (City) (State) (Zip Code)

Social Security #: _____ Date of Birth: _____

Marital Status: ☐ Single ☐ Married ☐ Other Email Address: _____

Race (*optional*): ☐ Caucasian ☐ Hispanic ☐ African American ☐ Asian ☐ Native American ☐ Pacific Islander ☐ Other

Daytime Phone: _____ Evening or Cell Phone: _____

Family Doctor (*First & Last Name)*: _____

Authorization Number (Internal Use Only)_____

Responsible Party

(Person Responsible for the bill)

Name: _____ Date of Birth: _____

Social Security #:_____ Employer: _____

Primary Insurance Information		Secondary Insurance Information	
Policy Holder: *(Name)*		Policy Holder: *(Name)*	
Date of Birth:		Date of Birth:	
Social Security #:		Social Security #:	
Employer of Insured:		Employer of Insured:	
Name of Insurance:		Name of Insurance:	
Policy #:		Policy #:	
Group Name:	Group Number:	Group Name:	Group Number:

Emergency Contact

Name: _____ Relationship to Patient: _____

Daytime Phone: _____ Evening or Cell Phone: _____

Your driver for today if different from above: _____ Phone: _____

Release of Benefits and Information: *(please read carefully)*
I authorize my insurance benefits to be paid directly to Eastside Endoscopy Center, LLC. I understand that I am financially responsible for any balance due. I authorize Eastside Endoscopy Center, LLC or the Insurance Company to release any information for these claims.

Signature: _____ Date: _____

Eastside Endoscopy Center is not a part of Northwest Gastroenterology or Overlake Internal Medicine, it is a separate entity.