CAPITAL DIGESTIVE CARE
First in Digestive Health

Associates in Gastroenterology

Patient Profile

Doctor:			Appointment Date/Time	
Name:			Patient ID #:	Sex: ☐ M ☐ F
Preferred:			Date of Birth:	
Address:			Social Security #:	
			Marital Status: ☐ Married ☐ Single ☐ Divorced	
City, State, Zip			Referring Physician:	
Alt. Address:			Primary Physician:	
			Preferred Language:	
			Email Address:	
Alt. City, State			**Contact By:**	
Phone: ( )	☐ Home ☐ Work ☐ Other		***Preferred Pharmacy:***	
Phone: ( )	☐ Home ☐ Work ☐ Other		Pharmacy Name:	
Phone: ( )	☐ Home ☐ Work ☐ Other		Address:	

PATIENT EMPLOYMENT	**EMERGENCY CONTACTS**
[ ] Employed [ ] Retired [ ] Unemployed [ ] Other	
Phone:	
Employer:	

PERSON RESPONSIBLE FOR PAYMENT	**EMPLOYMENT**
[ ] Same as Patient	Employer:
Name:	Phone:
Address:	Alt. Phone:
	Social Security #:
City, State:	Date of Birth:

PRIMARY INSURANCE	
[ ] Same as Patient [ ] Same as Guarantor [ ] Other	
Insured Party:	Relationship to Primary Insured/Guarantor:
Insured Phone:	Social Security #:
Company:	Insured ID:
	Policy Group:
	Date of Birth:

SECONDARY INSURANCE	
[ ] Same as Patient [ ] Same as Guarantor [ ] Other	
Insured Party:	Relationship to Primary Insured/Guarantor:
Insured Phone:	Social Security #:
Company:	Insured ID:
	Policy Group:
	Date of Birth:

The above information is true and correct. I understand that I am financially responsible for any balances not covered by my insurance. I will pay those balances due within 20 days of receipt of a statement. If collections become necessary, I will be responsible for any cost incurred.

Signature : _____ Date: _____