

# Airport Endoscopy Center

## Patient & Insurance Information Record

### Patient Information

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

DOB: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Male/Female: \_\_\_\_\_

Social Security # \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Responsible Party: \_\_\_\_\_ Phone: \_\_\_\_\_

### Primary Insurance Information

Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Precert #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Insured's DOB: \_\_\_\_\_ Employer: \_\_\_\_\_

Claims Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Secondary Insurance Information

Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Precert #: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Insured's DOB: \_\_\_\_\_ Employer: \_\_\_\_\_

Claims Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Patient/Guarantor Signature: \_\_\_\_\_ Date: \_\_\_\_\_