Strand GI Endoscopy Center, Inc **Patient Demographic Sheet**

Acct#_______________ **Patient Information** Today's Date: _____/_____/_________

Patient's Legal Last Name________________________________ First Name:_______________________________________ Middle Initial: _______

Preferred Name: ________________________ Social Security #: __________/_________/_______________

Pt's Home Address: ____ Apt/Suite #: ___________

City: ____ State: ________________________ Zip Code+4: ______________- _________

Pt's Mailing Address(if different):____

Home Phone:_______________________________ Work Phone:__________________________ Ext: ________ Cell Phone:______________________

Patient's Gender: ☐Male ☐ Female Date of Birth: ______/_______/___________ Age:_____________

Employer: ____ Personal Email: ____

Physician That Referred You to Us: ________________________________ **Name of Primary Care Physician:** ______________________________

Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Employment Status: ☐Full-time ☐Part-time ☐Not Employed ☐Self-Employed ☐Retired ☐Military Duty ☐Disabled

Student Status: ☐Full Time ☐Part Time **Relationship to Responsible Party:** ☐Self ☐Spouse ☐Child ☐Other: ______________

Financial Account Information

Name of Person Financially Responsible for this Account: ☐ Self ☐Other: ____

Address: ____ Apt/Suite #: ___________________

City: ____ State: _________________ Zip + 4 _____________- _________

Home Ph: _______________________________ Work Ph: ____________________________ Ext: __________ Cell Ph: ______________________

Gender: ☐Male ☐Female Date of Birth: ______/_______/_________ SSN# _________-__________- _____________

Employer____ E-mail Address____

Insurance Information

Primary Insurance Company: ____

Claims/Insurance Company Address: ____

City: ________________________________ State: ____________________ Zip + 4: __________-_________ Effective Date: _____/_____/_________

Name of Policy Holder: ____ Patient's ID#: ______________________________________

Group Name: ______________________________________ Group #: ___________________________________

Claims Phone #: _____________________________________ Patient's Relationship to Policy Holder: ☐Self ☐Spouse ☐Child ☐Other

Policy Holder's Date of Birth: _________/______/__________ Policy Holder's SSN #: __________/ _________/ ______________

Secondary Insurance Company: ____

Claims/Insurance Company Address: ____

City: ________________________________ State: ____________________ Zip + 4: __________-_________ Effective Date: _____/_____/_________

Name of Policy Holder: ____ Patient's ID#: ______________________________________

Group Name: ______________________________________ Group #: ___________________________________

Claims Phone #: _____________________________________ Patient's Relationship to Policy Holder: ☐Self ☐Spouse ☐Child ☐Other

Policy Holder's Date of Birth: _________/______/__________ Policy Holder's SSN #: ___________/ _________/ ______________

Emergency Contact Information

Name: Last: ____, First: ___________________________________ MI: _________

Work Ph: ____ Ext: _______ Cell Ph: _________________________________

Do you have a Living Will/Advanced Directive? ☐ Yes ☐ No *(If yes, please provide us with a copy on the day of your procedure)*

I hereby authorize payment of medical benefits to SGIEC for services provided. I authorize the release of any medical information necessary to process this claim and all future claims
I fully understand that I am financially responsible for payment of services not covered by my insurance. I hereby specifically agree to pay the Center any outstanding balance once insurance claims have processed in accordance with the terms and rates then in effect.

____
Signed (Responsible Party or Policy Holder)

I understand as the patient I should stop taking any medications as specified in my prep instructions. I understand that if I fail to stop these medications as directed, my procedure will be cancelled and rescheduled for my safety.

____
Signed (Responsible Party or Policy Holder)

PLEASE COMPLETE THIS ENTIRE FORM AND BRING WITH YOU ON THE DAY OF YOUR PROCEDURE!