2214 Old Emmorton Rd, Suite 100
Bel Air, MD 21015 (410) 838-6345

PATIENT DEMOGRAPHIC INFORMATION

NAME____ SS #_______-_______-_______
LAST FIRST MI

ADDRESS________________________________ APT____________ DATE OF BIRTH ____-____-_____

CITY ________________________ STATE_______ ZIP CODE _________ MARITAL STATUS: □ S □ M

HOME PHONE____________________ WORK PHONE__________________ □ D □ W

CELL PHONE____________________ EMAIL______________________ SEX: □ Male □ Female

EMPLOYER______________________________________ DRUG ALLERGIES: ______________
(If retired-give name of company)

ADDRESS______________________________________

REFERRING PHYSICAN______________________________

ADDRESS/PHONE__________________________________

WHOM TO NOTIFY IN CASE OF EMERGENCY

NAME____ RELATIONSHIP______________________

ADDRESS______________________________________ HOME PHONE________________________

CITY __________________ STATE______ ZIP CODE ________ WORK PHONE________________________

Please Check off the following. This information is requested by the Department of Health and Mental Hygiene, for Statistical reporting purposes only.
Your Response is appreciated.

ETHNICITY

☐ 1. African American ☐ 2. American Indian/Eskimo ☐ 3. Asian ☐ 4. Hispanic ☐ 5. Pacific Islander ☐ 6. Caucasian ☐ 7. Other

PRIMARY INSURANCE

COMPANY__________________________ ***POLICY HOLDER'S***

ADDRESS__________________________ NAME____________________ SS #_______-_______-_______

__________________________________ DATE OF BIRTH______________ POLICY#________________

PHONE____________________________ EMPLOYER____________________GROUP#________________

SECONDARY INSURANCE

COMPANY__________________________ ***POLICY HOLDER'S***

ADDRESS__________________________ NAME____________________ SS #_______-_______-_______

__________________________________ DATE OF BIRTH______________ POLICY#________________

PHONE____________________________ EMPLOYER____________________ GROUP#________________

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize release of any medical information necessary to process any insurance claims and authorize payment of medical benefits directly to HARFORD GASTROENTERLOGY ASSOCIATES, P.A./HARFORD ENDOSCOPY CENTER for myself or my dependents. I understand that I am responsible for any Deductibles, Co-Insurance, Co-pays, or other amounts not covered by my insurance companies. If a referral is required and is not presented at time of service, service will be denied until the referral is obtained.

DATE__________________________ SIGNATURE____

CONFIRMATION OF PATIENT INFORMATION ON DAY OF PROCEDURE/APPT.

I have reviewed my patient demographic and insurance information on this date and verify that all information reported to the Center is correct.

DATE__________________________ SIGNATURE____