Harford Endoscopy Center

**2214 Old Emmorton Rd, Suite 100**
**Bel Air, MD 21015**
**Ph.: (410) 838-6345 Fax: (410) 838-1595**

# PATIENT DEMOGRAPHIC INFORMATION

NAME_____ SS #_____-_____-_____
LAST FIRST MI

ADDRESS_____ APT_____ DATE OF BIRTH ____-____-_____

CITY _____ STATE_____ ZIP CODE _____ MARITAL STATUS: □ S □ M □ D □ W

HOME PHONE_____ WORK PHONE_____

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_____