PATIENT REGISTRATION FORM

The Endoscopy Center
at Bainbridge, LLC
8185 East Washington St. | Suite 106 | Chagrin Falls, OH | 44023
P 440-708-0582 | F 440-708-0583

Patient Information

Patient Name: _____ ☐ **Male** ☐ **Female**

Address: _____
Street City State Zip

Mailing Address: _____
(if different from above)

Date of Birth: _____ Social Security #: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

Referring Physician: _____ Referring Physician Phone: _____

Insurance Information

Primary Policy Holder	Secondary Policy Holder (if applicable)
Date of Birth	Date of Birth
SSN of Primary Insured	SSN of Secondary Insured
Employer of Insured	Employer of Insured
Name of Primary Insurance	Name of Secondary Insurance
Effective Date	Effective Date
Group No.	Group No.

Emergency Contact

Name/Relationship: _____ Phone: _____

Release of Benefits and Information

I authorize my insurance benefits to be paid directly to The Endoscopy Center at Bainbridge. I understand that I am financially responsible for any balance due. I authorize The Endoscopy Center at Bainbridge or the insurance company to release any information for these claims.

Signature: _____ *Date:* _____

Name/Relationship of Driver: _____ *Cell Phone:* _____