Carlisle Digestive Disease Associates, Ltd.
Carlisle Endoscopy Center, Ltd.
241 Alexander Spring Road • Carlisle, PA 17015

PATIENT REGISTRATION INFORMATION (Please *PRINT* clearly)

PATIENT NAME

SOCIAL SECURITY NUMBER ☐ MALE ☐ FEMALE

ADDRESS

PATIENT SEX

CITY, STATE, ZIP

PATIENT BIRTH DATE

HOME TELEPHONE NUMBER

WORK TELEPHONE NUMBER

CELLULAR PHONE NUMBER

EMAIL ADDRESS

FAMILY DOCTOR

EMPLOYER

REFERRING DOCTOR

MARITAL STATUS

EMERGENCY CONTACT PERSON(S) (please include telephone numbers)

NAME HOME WORK CELLULAR

NAME HOME WORK CELLULAR

PATIENT INSURANCE INFORMATION (please *PRINT* clearly) **Please provide insurance cards for copy**

PRIMARY

SECONDARY

ID #

ID #

GROUP #

GROUP #

Subscriber's name & address (if different from patient)

Subscriber's name & address (if different from patient)

Patients relationship to subscriber:
◯ Self ◯ Spouse ◯ Dependent ◯ Other

Patients relationship to subscriber:
◯ Self ◯ Spouse ◯ Dependent ◯ Other

Subscriber's Birth Date:

Subscriber's Birth Date:

Payment Authorization

I authorize Carlisle Digestive Disease Associates, Ltd. and/or Carlisle Endoscopy Center, Ltd. to furnish any information to my insurance carrier needed to submit medical claims. I direct the insurer to pay directly to the physician all benefits due him as a result of claims submitted on my behalf. ***ALTHOUGH COVERED BY INSURANCE, I AM AWARE THAT I AM PERSONALLY RESPONSIBLE FOR ALL CHARGES***. A copy of this authorization will be valid as the original.

Signature: Date: