# ELMS DIGESTIVE

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ACCOUNT #_____ DOCTOR_____ (OFFICE USE)

PRIMARY CARE DOCTOR_____ REFERRING DOCTOR_____

NAME_____ MALE ☐ FEMALE ☐

ETHNICITY_____ RACE_____ LANGUAGE_____

MAILING ADDRESS_____ BIRTH DATE_____

CITY_____ STATE_____ ZIP CODE _____

HOME PHONE_____ CELL PHONE_____ E-MAIL ADDRESS_____

SSN_____ SINGLE ☐ MARRIED ☐ WIDOWED ☐ OTHER ☐

PLACE OF EMPLOYMENT_____ WORK PHONE_____

PHARMACY_____ PHONE #_____

LOCATION_____

EMERGENCY CONTACT_____ RELATIONSHIP _____

PHONE #_____ SECURITY PASSWORD (YOUR MOTHER'S MAIDEN NAME) _____

PRIMARY INSURANCE_____ PT. REL. TO INSURED: SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

INSURED NAME_____ BIRTH DATE_____

ID #_____ GROUP_____ SPOUSE SS#_____

SECONDARY INSURANCE_____ PT. REL. TO INSURED: SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

INSURED NAME_____ BIRTH DATE_____

ID #_____ GROUP_____

This office participates with many, but not all, insurance companies. It is the patient's responsibility to inform us of any insurance coverage. You are responsible at the time of service for any **Co-Payment** amount mandated by your insurance company. If you do not know your **Co-Payment**, you will automatically get charged $20.00 due at check out time. Our office will file your claims and await payment. Once your insurance company has responded to our claim, you will be billed for any balance due on your account. The ultimate responsibility is **YOURS** regarding payment of any balance due on your account.

DATE_____ SIGNATURE_____