



**CATALINA
GASTROENTEROLOGY**
PATIENT REGISTRATION
1845 W. Orange Grove Rd. Suite 125
297-3911

Patient Name (Last): _____ First: _____ Init: _____

Address: _____ Apt. #: _____ City, State & Zip: _____

Home Phone: _____ Work Phone: _____ DOB: _____

Patient Social Security #: _____ Male ___ Female ___ Marital Status: M ___ S ___ D ___ W ___

Patient Employer: _____ Address: _____

Occupation: _____ Work Status: _____ Student Status: _____

Primary Care Physician: _____

Responsible Party name: _____ Relationship to Patient: _____

Responsible Party Social Security #: _____ DOB: _____

EMERGENCY CONTACT: _____ **PHONE #:** _____

Primary Insurance Company: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Relationship to Patient: _____ Employer: _____

Policy Number: _____ Group Number: _____

Co-pay: _____ Deductible: _____

Effective Date of Coverage: _____

Secondary Insurance Company: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Relationship to Patient: _____ Employer: _____

Policy Number: _____ Group Number: _____

Effective Date of Coverage: _____

Where did you hear about Dr. Lee-Collins? _____

Do you have a living will? YES NO

I certify that information provided pertaining to my health insurance coverage is true and correct. I authorize that payment for services rendered should be made payable to Catalina Gastroenterology. I authorize release of medical information necessary to process this (these) claim(s). I have read all the terms and conditions contained in this agreement and agree to be bound by these terms and conditions.

Signature: _____ Date: _____