colon & rectal surgery associates

Patient Name: _____ Date of Birth: _____ Age: _____

Patient Sex: _____

Patient Address: _____

_____

_____

Please tell us the race that describes you: _____

In what Language can we best serve you? _____

Ethnicity: Is your Ethnic background Hispanic or Latino? _____

We want to make sure that all our patients get the best care possible. We would like you to tell us your race, language and ethnic background so that we can make sure that all patients receive the highest quality of care. Your answers will be kept confidential. You have the right to decline this information and declining to answer will have no effect on the care you receive.

Home Phone: _____ Primary Care Physician: _____

Day Phone: _____ Care System: _____

Cell Phone: _____

E-Mail: _____

Employer: _____ Occupation: _____

Work Phone: _____

Primary Insurance: _____ ID #: _____

Policy Holder: _____ Relation: _____ DOB: _____

Secondary Insurance: _____ ID#: _____

Policy Holder: _____ Relation: _____ DOB: _____

Other providers involved in your care and their specialty:

_____

_____

_____