



**colon & rectal surgery associates**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Patient Sex: \_\_\_\_\_

Marital Status: \_\_\_\_\_

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: \_\_\_\_\_

Hospital Preference: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ ID #: \_\_\_\_\_ Group#: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

Other providers involved in your care and their specialty:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_