COLON AND RECTAL SURGERY ASSOCIATES, LTD.

PATIENT REGISTRATION INFORMATION

ACCOUNT NUMBER

REFERRING PHYSICIAN:	TELEPHONE:
PRIMARY PHYSICIAN:	TELEPHONE:

PATIENT NAME: first initial last Mr. Miss. Dr. Ms. Mr.	BIRTHDATE:	AGE:	SEX:

ADDRESS:	STREET	APT#	CITY:	STATE:	ZIP CODE:

HOME TELEPHONE:	SOCIAL SECURITY NUMBER:

PATIENT'S EMPLOYER:	DEPARTMENT/OCCUPATION:	TELEPHONE(include extension)
SPOUSE/GUARDIAN NAME:	EMPLOYER:	TELEPHONE(include extension)

EMERGENCY CONTACT: (outside of the home) name-telephone-relationship

PRIMARY INSURANCE:

IDENTIFICATION/POLICY NUMBER:	GROUP NUMBER:	PLAN NUMBER:
POLICY HOLDER NAME:	BIRTHDATE:	SOCIAL SECURITY NUMBER:

SECONDARY INSURANCE:

IDENTIFICATION/POLICY NUMBER:	GROUP NUMBER:	PLAN NUMBER:
POLICY HOLDER NAME:	BIRTHDATE:	SOCIAL SECURITY NUMBER:

I hereby authorize COLON AND RECTAL SURGERY ASSOCIATES, LTD. to furnish information concerning my illness and treatments to INSURANCE CARRIERS, PHYSICIANS directly in my care, and for purposes of quality review and medical research studies. I authorize payment of any medical benefits to COLON AND RECTAL SURGERY ASSOCIATES, LTD. I certify that the above information is correct and that I am responsible for payment of services rendered. I permit a copy of this authorization to be used in place of the original.

DATE: ______________________ SIGNATURE: X____

CONSENT FOR TREATMENT: I do hereby voluntarily consent to diagnostic procedures and medical treatment by members of COLON AND RECTAL SURGERY ASSOCIATES, LTD. as necessary in my physician's professional judgment. I am aware that the practice of medicine is not an exact science and acknowledge no guarantees can be made about the result of such treatment.

DATE: ______________________ SIGNATURE: X____

MEDICARE AUTHORIZATION: I request that payment of authorized medical benefits be made on my behalf to COLON AND RECTAL SURGERY ASSOCIATES, LTD. for services furnished me by this clinic/physician/supplier. I authorize any holder of hospital or medical information about me to be released to the HEALTH CARE FINANCING ADMINISTRATION and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

DATE: ______________________ SIGNATURE: X____

THANK YOU FOR CHOOSING COLON AND RECTAL SURGERY ASSOCIATES, LTD.