ENDOSCOPY CENTER OF LONG ISLAND

PATIENT PERSONAL INFORMATION

Name: _____ **SS#:** ____-____-_____ **Birth Date:** ____/____/____ **Age:**_____
Last First

Sex: [ ] M [ ] F **Marital Status:** [ ] Single [ ] Married [ ] Widowed [ ] Divorced

Race: [ ] White [ ] Black/African American [ ] Amer. Indian/Native Alaskan

[ ] Asian Indian [ ] Chinese [ ] Filipino [ ] Japanese [ ] Korean [ ] Vietnamese [ ] Other Asian

[ ] Native Hawaiian [ ] Guamanian [ ] Samoan [ ] Other Pacific Islander [ ] Other Race

Ethnicity: [ ]Non-Hispanic [ ]Mexican/Chicano/Mex. Amer. [ ]Puerto Rican [ ]Cuban [ ]Other Hispanic/Latino [ ]Unk

Phone: Home:(_____)_____ **Work:**(_____)_____ **Cell:**(_____)_____

Other1:(_____)_____ **Other2:**(_____)_____

Home Address: _____
Street City State Zip

Emergency Contact: _____
Name Phone Relationship

Principal Language: _____ **Need Interpreter:** [ ] Yes [ ] No
if other than English

EMPLOYMENT INFORMATION:

Employer Name:_____ **Occupation:**_____

Employer Address: _____
Street City State Zip

Department/Branch/Supervisor: _____**Phone:**(____)_____

INSURANCE INFORMATION:

Primary: _____**Telephone#:**_____

Secondary: _____**Telephone#**_____

Tertiary: _____**Telephone#:**_____

ALLERGIES (food, medications, etc.)_____

PRIMARY CARE DOCTOR: _____

I understand that I may be financially responsible if my insurance company fails to make payment for my services. I also understand that I am responsible for any and all services that are considered non-covered by my insurance carrier and/or Medicare and agree to extend payment to the Endoscopy Center of Long Island for any and all non-covered services, co-insurances and plan deductibles.

X _____

Patient's Signature

X _____

Date

_____

Signature of Authorized Representative

_____

Relationship (if other than self)

Form Pt Personal Info (rev 06/13)