Akron Digestive Disease Consultants, Inc.

DEMOGRAPHICS FORM

FIRST NAME: _____ INITIAL: _____ LAST NAME: _____

SUFFIX: _____ MAIDEN/ALIAS NAME: _____DOB: _____LAST 4 SSN: _____

SEX: _____MARITAL STATUS: _____ STREET ADDRESS: _____

CITY: _____ ZIP: _____

PHONE(H): _____(C): _____(w): _____ (CIRCLE PREFERRED)

CHECK IF OK TO LEAVE DETAILED MESSAGE INCLUDING RESULTS AT PREFERRED NUMBER ☐

DO YOU HAVE A PREFERRED PHYSICIAN HERE? _____

EMAIL: _____ CONTACT PREFERENCE: MAIL PHONE EMAIL (CIRCLE ONE) _

IF YOU INDICATED EMAIL, YOU WILL BE SENT A REQUEST TO JOIN OUR PATIENT PORTAL TO RECEIVE EMAILS FROM US

PCP/REFERRING DR NAME/ NUMBER: _____

CHECK IF YOU ARE SELF REFERRED FOR SCREENING COLONOSCOPY ☐

PREVIOUS GI DR NAME: _____ *PLEASE ASK US FOR A ROI IF HAVE PREVIOUS GI*

PREFERRED PHARMACY NAME/NUMBER: _____

DO YOU HAVE A LIVING WILL Y/N DO YOU HAVE A POA Y/N

IF YOU HAVE EITHER, PLEASE PROVIDE US A COPY, IF YOU NEED A BLANK FORM LET US KNOW.

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____ SUBSCRIBER NAME IF NOT SELF: _____

SUBSCRIBER RELATIONSHIP TO PATIENT: _____ SUBSCRIBER DOB: _____

SECONDARY INSURANCE COMPANY NAME: _____ SUBSCRIBER NAME IF NOT SELF: _____

SUBSCRIBER RELATIONSHIP TO PATIENT: _____ SUBSCRIBER DOB: _____

AUTHORIZATION FOR TREATMENT, ASSIGNMENT OF BENEFITS, AND INFORMATION RELEASE:

I HEREBY REQUEST AND CONSENT TO TREATMENT AND SERVICES REASONABLE AND PROPER BY TODAY'S STANDARDS PROVIDED BY AKRON DIGESTIVE DISEASE CONSULTANTS, INC. AND AUTHORIZE COMPANIES FOR HIS/HER SERVICES AND I ASSUME RESPONSIBILITY FOR ANY UNPAID BALANCE INCLUDING NON CONVERED SERVICES EXCEPT AS LIMITED BY LAW. I ALSO HEREBY AUTHORIZE THE PHYSICIAN TO RELEASE ANY INFORMATION TO THE HEALTH CARE FINANCING AGENCY OR ITS AGENT, TO THIRD PARTY PAYERS AND ANYONE ASSISTING THE PROVIDER IN OBTAINING PAYMENT INCLUDING BILLING, CODING AND COLLECTION AGENTS, PROVIDER'S ATTORNEY, CONSULTANTS, AND TO MY INSURANCE COMPANY AS REQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT. THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. I REVIEWED AND ACCEPT THE AUTHORIZATION, ASSIGNEMENT AND INFORMATION RELEASEPAYMENT DIRECTLY TO THE PHYSICIAN OF MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME BY MEDICARE OR OTHER INSURANCE.

SIGNATURE (PATIENT OR REPRESENTATIVE : _____DATE : _____