HACKENSACK DIGESTIVE DISEASE ASSOCIATES, PA
Eric J Eliinghaus, MD Richard C Golding, MD, MPH David L Feit, MD David M Felig, MD
Mark E Tanchel, MD Rosario J Ligresti, MD Gunjan Kumar, MS, PA-C

PLS COMPLETE & BRING IN

DATE OF APPOINTMENT ______/______/______ WITH DOCTOR ______

PATIENT NAME ______
(First) (Middle) (Last)

ADDRESS ______ APT# ______

CITY ______ STATE ______ ZIP ______

PHONES:
HOME: (____)______ CELL: (____)______ WORK: (____)______ EXT# ______

SEX: **MALE** **FEMALE** RACE______ ETHNICITY______ PRIMARY LANGUAGE______

DATE OF BIRTH ______/______/______ SS# ______-______-______

MARITAL STATUS: **SINGLE** **MARRIED** **DIVORCED** **WIDOWED** **SEPARATED** **DOMESTIC PARTNER**

>> PREFERRED METHOD OF CONTACT: **TELEPHONE / POSTAL MAIL / EMAIL >** **EMAIL ADDRESS** ______

>> PLEASE PROVIDE A COPY OF YOUR **DRIVER'S LICENSE** or STATE **IDENTIFICATION CARD** <

EMPLOYER ______ OCCUPATION ______

BUSINESS ADDRESS ______
(STREET) (CITY) (STATE) (ZIP)

SPOUSE or NEXT-OF-KIN + RELATIONSHIP ______ PHONE (____) ______

EMERGENCY CONTACT+ RELATIONSHIP ______ PHONE (____) ______

PRIMARY CARE PHYSICIAN ______ **REFERRING** PHYSICIAN ______

ADDRESS ______ ADDRESS ______

MEDICATION **ALLERGIES** ______

PHARMACY NAME+PHONE ______

REASON FOR VISIT TODAY ______

PRIMARY INSURER ______ EFFECTIVE DATE ______

ID# ______ GROUP # ______ EMPLOYER ______

INSURED'S NAME+RELATIONSHIP TO PATIENT ______ INSURED'S DATE OF BIRTH ______

SECONDARY INSURER ______ EFFECTIVE DATE ______

ID# ______ GROUP # ______ EMPLOYER ______

INSURED'S NAME+RELATIONSHIP TO PATIENT ______ INSURED'S DATE OF BIRTH ______

* IF YOU HAVE A TERTIARY POLICY, PLEASE PROVIDE THAT INFORMATION ON THE **REVERSE OF THIS FORM** *

I AUTHORIZE THE RELEASE OF ANY MEDICAL RECORDS NECESSARY TO PROCESS INSURANCE CLAIMS AND AUTHORIZE PAYMENT **HACKENSACK DIGESTIVE DISEASE ASSOCIATES, PA.** I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE OR COPAYMEI DUE PER MY INSURANCE COVERAGE.

> *THERE IS A FEE OF $100 FOR PROCEDURES AND $50 FOR OFFICE VISITS CANCELLED WITHOUT 48 HOURS PRIOR NOTICE.*
> *THIS MUST BE PAID BEFORE A PROCEDURE OR VISIT IS RESCHEDULED.*

SIGNATURE ______ DATE ______

>>*PLEASE USE THE **REVERSE SIDE** FOR ANY ADDITIONAL PERTINENT INFORMATION. THANK YOU.*