DIGESTIVE DISEASE ASSOCIATES
PATIENT INSURANCE AND DEMOGRAPHICS FORM

Treating doctor (please check) ○ Abernathy ○ Afzal ○ Alex ○ Andorsky ○ Banegura ○ Crosse ○ Joy ○ C Kim ○ P Kim
○ Narayen ○ Ravendhran ○ Salas ○ Sardana ○ Solomon ○ Tavassolie ○ van den Broek

Patient Information

○ Dr. ○ Mrs. ○ Ms. ○ Miss ○ Mr. Today's Date: ____________________________

First Name: ____________________________ Middle : ________________________ Last : ________________________________

Street Address:____City, State, Zip: ______________________________________

Home Phone#: __________________________ Work Phone#:________________________Cell Phone#: ________________________

When we contact you to remind you of your appointment, should we contact your?: ○ Home # ○ Cell Phone #

E-mail Address: __________________________________ Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed ○ Separated

Race: ○ American Indian ○ Asian ○ Black or African American ○ White ○ Declined ○ Other ____________________________

Ethnicity: ○ Hispanic or Latino ○ Not Hispanic or Latino ○ Declined ○ Other ____

Language: ○ English ○ Spanish ○ Indian ○ Chinese ○ Korean ○ Other ____

Birth Date: _______________________ Sex: ○ Male ○ Female Social Security #: ____

Employer: ____

In case of emergency, notify:____ Daytime Phone #: ____________________________

Financially Responsible Person: ○ Self ○ Parent Name, if different than patient: ____

Address, if different than patient: ____

Phone#, if different than patient: _________________________________

Primary Insurance Section:

Company Name: ____Phone #: __________________________

Claims Address: ____

Policy Number: ____Group #: ____

Name of Policy Holder: ________________________________Employer: ____

Policy Holder's Birth Date:____________________Sex: ○ Male ○ Female Relationship To Patient: ____________________________

Social Security #: __________________________Co-Payment Amount: $________ Plan Effective Date: __________________

Secondary Insurance Section:

Company Name: ____Phone #: __________________________

Claims Address: ____

Policy Number: ____Group #: ____

Name of Policy Holder: ________________________________ Employer:____

Policy Holder's Birth Date:____________________Sex: ○ Male ○ Female Relationship To Patient:_____________________________

Social Security #: ________________________Co-Payment Amount: $___________Plan Effective Date: __________________

Referring and Primary Care Physician Section:

Referring Physician (RP): ____ RP Phone #: __________________________

Primary Care Physician (PCP): ____ PCP Phone #: __________________________

Referral Information Section:

How were you referred to our practice?: ○Primary Care Physician ○Other Physician ○Our web site ○Friend ○Relative

○ Emergency Room ○ Hospital (Please specify physician): ____________________○ Other: (Please specify): ______________________

Pharmacy Information:

Pharmacy preference: ____ Phone Number: ________________________________

Address: ____