SOUTH FLORIDA COLORECTAL INSTITUTE
ELIE SCHOCHET, M.D.

PATIENT REGISTRATION FORM

Patient Name: _____ Social Security Number: _____ - _____ - _____

Date of Birth: _____/_____/_____ Age: _____ Sex: M / F / T / Other Married / Single / Partner / Divorced / Widow(er)

Phone: (_____) _____ - _____ Email: _____

Address: _____
(Street) (City/State/Zip)

Preferred Pronoun: _____ Race: _____ Ethnicity: _____

Employer Name: _____ Employer Phone: (_____) _____ - _____

Primary Care Physician: _____
(Name) (Phone)

Pharmacy: _____
(Name) (Address) (Phone)

How did you hear about our Practice? _____

Person responsible for bill (*Complete only if different from patient*)

Guarantor Name: _____ Guarantor Phone: (_____) _____ - _____

Relationship to Patient: (please check): ( ) self ( ) spouse ( ) parent ( ) partner Date of Birth: _____/_____/_____

Address: _____
(Street) (City/State/Zip)

Emergency / Alternate Contact

Name: _____ Relationship:_____

Home Phone: (_____) _____ - _____ Alternate Phone: (_____) _____ - _____

PRIMARY INSURANCE INFORMATION

Plan Name: _____ I.D. Number: _____
Address: _____ Group Number: _____
Policy Holder's Name (write SELF if patient): _____
Policy Holder's Social Security Number: _____ - _____ - _____
Policy Holder's Date of Birth: _____/_____/_____

SECONDARY INSURANCE INFORMATION

Plan Name: _____ I.D. Number: _____
Address: _____ Group Number: _____
Policy Holder's Name (write SELF if patient): _____
Policy Holder's Social Security Number: _____ - _____ - _____
Policy Holder's Date of Birth: _____/_____/_____

I acknowledge that I am ultimately financially responsible for payment whether or not services are covered by my insurance. I acknowledge that any out of pocket costs (ie; deductible, coinsurance, copayment) incurred from services rendered by Dr. Elie Schochet are my responsibility. By signing below, I understand and comply with the above statements regarding my financial responsibility to South Florida Colorectal Institute, Elie Schochet, M.D.

Signature: _____ **Date:** _____

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