Digestive Care Specialists

1026 E. 2nd St. Casper, WY 82601
Phone: 307-333-0002
Fax: 307-333-4425

Patient Information

Today's Date_____ **Primary Care Provider**_____

Printed Name of Patient (first, middle, last name)		
Date of Birth (MM/DD/YYYY)	Social Security	Gender: ___Male ___Female
Address (Street Address, City, State, Zip Code)		
Phone Number:	E-mail	

May we leave confidential messages (appointment reminders, test results, etc.) on your home answering machine or voice-mail? ___YES ___NO

Other than your home phone, where do you want to receive calls about your appointments, lab and x-ray results or other health care information?

Cell Phone_____ Work_____

May we leave a message? ___YES ___ NO

Authorized Parties to Speak with Regarding Medical Information_____

Marital Status: ___Single ___Married ___Divorced ___Widowed	Primary Caregiver: ___Self ___Other_____	
Race: ___American Indian/Alaskan Native ___African American ___Native Hawaiian/Pacific Islander ___Caucasian ___Multiracial ___Other		
Ethnicity: ___Hispanic/Latino ___Non-Hispanic/Latino ___Other	Primary Language ___English ___Spanish ___Other	Advanced Directive? ___Yes ___No

Employer_____Occupation_____Telephone_____

Authorized Parties to Speak with Regarding Billing_____

Emergency Contact Information:

Name:_____ Relationship:_____

Telephone Home_____ Work_____Cell_____

How did you hear about Digestive Care Specialists? Referred by_____

Website ___Yes ___No **If advertisement where**_____

Patient Insurance Information

Patient Name _____ Date of Birth _____/_____/_____

Primary Insurance: ☐ Scanned

Insured Party ___Self ___Spouse ___Parent ___Other (please specify) _____	Name of Policy Holder
Date of Birth	SSN
Member ID	Group Number
Claims Billing Information _____Address_____City_____State_____Zip	

Secondary Insurance: ☐ Scanned ☐ Not Applicable

Insured Party ___Self ___Spouse ___Parent ___Other (please specify) _____		Name of Policy Holder
Date of Birth		SSN
Member ID		Group Number
Claims Billing Information _____Address_____City_____State_____Zip		

Parties Responsible for Payment(if other than the patient)

Name	Social Security
Date of Birth (MM/DD/YYYY)	Phone Number:
Address (Street Address, City, State, Zip Code)	

I hearby authorize medical treatment of the above-named patient and agree to be financially responsible for all charges for such treatment, including cost of collections and legal fees (if applicable). I hereby assign payments to Digestive Care Specialists. I authorized Digestive Care Specialists to release medical information necessary to procccess my insurance claims. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

Patient/Guardian Signature_____ Date _____/_____/_____