Patient Registration

(Please Print)

Name____ Date of Birth_____/_____/______ Age________
(Last) (First) (MI)

Address_____________________________________ City______________________ State___________ Zip__________

Social Security Number _______-______-__________ Marital Status __________________ Sex: Male / Female

Phone # (______) _______-_________ Cell # (______) _______-_________ Work # (______) _______-__________

Employer ________________________ Primary Doctor______________________________ ☐ None

Ethnicity/ Race: ☐ Hispanic or Latino

☐ Not Hispanic / Not Latino

- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black/African American
- ☐ White
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Other __________________________

Language Preferred: __________________________

Pharmacy Name: _______________________ Location___________________________ Phone # (____) ______-______

Spouse's Name ____________________________ Date of Birth____/____/______Social Security_____-_____-________
(Last) (First) (MI) (**if covered under spouse's INS**)

In case of emergency, who should be notified?

____ Phone # (______) _______-__________

Nearest relative not living with you:

____ Phone # (______) _______-__________

Relationship___________________________ Address ____

I the undersigned have insurance coverage with ____ and assign
(Name of Insurance Co)
directly to **Hillsboro Gastroenterology, PC** and **Jeremy M. Lake, M.D. LLC** and **Barry A. Ross, M.D.** all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

X____ Date _____________________________