COLORECTAL SURGERY SERVICES, PLLC
Hemorrhoid Institute of South Texas

19016 Stone Oak Parkway, Suite 150 San Antonio, TX 78258
1201 South Main Street, Suite 122, Boerne, TX 78006
Office: 210-490-2828 Toll-free: 1-866-259-3778 Fax: 210-490-0505

REGISTRATION FORM

❑New Patient ❑Established Patient Account #: ______________________________

PATIENT INFORMATION:

Patient's Last Name:____________________________First Name:_________________MI:_______

Street Address:_____________________________City____________________State:_____ZIP:_________

Home Phone:____________________Cell Phone:_________________Work Phone:______________

Email Address:__________________________________ Primary Language:__________________

Sex: ❑ M ❑ F Marital Status: ❑Single ❑Married ❑Long-Term Partner ❑Divorced ❑Separated

Date of Birth:___/___/___ Driver's License #:_____________State:____Social Security #:______________

Employer Name:___________________________________Employer Phone:__________________

Employer Street Address:__________________________City:______________State:_______ZIP:____________

Spouse Name:_________________Date of Birth: ____/____/____ Social Security #:_____-_____-______

Spouse's Employer Name:__________________________Spouse's Employer Phone:_____________

Employer Street Address:_________________________City:__________________State:_____ZIP:_________

Emergency contact:____________________________________ Phone:__________________

INSURANCE INFORMATION: A Copy of your Insurance Card(s) and Driver's License (photo ID) is Required

Primary Insurance:____Phone:________________________

Policy Holder Name:____________________________Policy ID:_____________Group #:_________

Secondary Insurance:____Phone:________________________

Policy Holder Name:___________________________Policy ID:___________Group #:_____________

COMMUNICATION AUTHORIZATION – Please Complete

We are committed to providing private and efficient communication with you. Please indicate the preferred method(s) of contact, should we need to reach you by phone. Place an "X" in the appropriate box (es).

❑Home ❑message to return call ❑ detailed message (results, treatment) ❑NO Message ❑voice mail ❑with individual
❑Work ❑message to return call ❑ detailed message (results, treatment) ❑NO Message ❑voice mail ❑with individual
❑Cellular ❑message to return call ❑ detailed message (results, treatment) ❑NO Message ❑voice mail ❑with individual

In certain instances, it may be necessary to communicate via email: ❑ Yes - Email ❑No – Email

RELEASE OF INFORMATION POLICY – Please Read

I hereby authorize Colorectal Surgery Services, PLLC to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment, and other health care operations. My protected information may be released to the following individual(s):

Name:____DOB:________________Relationship to Patient:___________________

Name:____DOB:________________Relationship to Patient:___________________

Name:____DOB:________________Relationship to Patient:___________________

FINANCIAL POLICY – Please Read

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Colorectal Surgery Services or insurance company to release any information required to process my claims.

NOTICE OF PRIVACY POLICIES – Please Read

I acknowledge that I have been provided the “Notice of Privacy Practices” for Colorectal Surgery Services, PLLC. I acknowledge that I have completed this form and certify that I am the patient or duly authorized to furnish the information requested.

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Signature of Patient or Responsible Party Date