

Colon & Rectal Surgeons of Greater Hartford, LLC

PATIENT INFORMATION

PLEASE PRINT CLEARLY

Pt. No. _____

Patients Name _____ Sex M/F _____ Marital Status _____ Age _____
Address _____ Date of Birth _____
City _____ State _____ Home Phone# _____
Zip Code _____ S.S.# _____ Driver's Op. # _____
Employer Name _____ Work Phone# _____ Ext. _____
Employer's Address _____ Occupation _____
Referring Doctor _____ Primary Doctor _____
Nearest Relative (not living with you) _____ Phone # _____

Primary Insurance Company _____
Name of Insured _____ Relationship _____
Date of Birth _____ Employer's name _____
Insurance I.D. # _____ Policy/Group # _____
Secondary Insurance Company _____
Name of Insured _____ Relationship _____
Date of Birth _____ Employer's name _____
Insurance I.D. # _____ Policy/Group # _____
Comments _____

MEDICAL HISTORY

Previous Surgery: _____
Do you have any history of disease of the heart, lungs, kidney, high blood pressure? _____
If yes, please explain: _____
Do you have family history of heart disease, cancer, or diabetes? _____
If yes, please explain _____
Are you taking any medications now? (please specify) _____
Are you allergic to any medications? _____

AUTHORIZATION AND RELEASE: I hereby authorize release of any medical information necessary to process my insurance claim, and request payment of medical benefits be made directly to **COLON & RECTAL SURGEONS OF GREATER HARTFORD** for services rendered to me by the above named physician and/or physician group.

I understand that any amount deemed by my insurance carrier to be beyond the "usual, reasonable and/or customary" charges for said services will be paid by me. I recognize and accept personal responsibility for immediate payment of charges not covered by my contract and agree to pay attorney's fees, court costs, and any other responsible costs of collection should I fail to make payment

Signature: _____ Date: _____