INTEGRATED COLORECTAL CARE

Michael H. Polcino III, MD PLLC

PATIENT REGISTRATION

Today's Date: _____/_____/_____

How did you hear about us? _____

Name: _____

Address: _____ City: _____ Zip: _____

E-Mail: _____

Date of Birth: _____/_____/_____ Marital Status: S☐ M☐ W☐ D☐

Preferred Language (*if other than English*): _____

Phone: Home #: ( ) _____-_____ Cell #: ( ) _____-_____

Employer: _____ Work #: ( ) _____-_____

Primary Care Physician: _____ Phone: ( ) _____-_____

Address: _____ City: _____ Zip: _____

Pharmacy Name: _____ Phone: ( ) _____-_____

Address: _____ City: _____ Zip: _____

MEDICAL INSURANCE INFORMATION

Insurance Company: _____

Policy #: _____ Group: _____

Name of Policy Holder: _____ Relationship: _____

Policy Holders Employer: _____

Insured's Date of Birth (leave blank if patient is policy holder): _____/_____/_____

Do you have secondary insurance? No ☐ Yes ☐ : _____
Secondary Insurance Name

I, the undersigned, have insurance with the above noted insurance(s) and assign directly to Dr. Michael H. Polcino III 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. And authorize the use of this signature on all of my submissions.

Patient Signature: _____ Date: _____/_____/_____