SCOTTSDALE ENDOSCOPY CENTER
9787 N. 91ST STREET, SUITE 103
SCOTTSDALE, AZ 85258

PHONE: 480-657-0889 FAX: 480-657-9277

PLEASE FILL OUT THE ENTIRE FORM AND SIGN AT THE BOTTOM SO WE MAY BILL YOUR INSURANCE COMPANY.

SS#: ________-________-________ Patient's Name: ______________________________________
LAST NAME **FIRST NAME** **MIDDLE INITIAL**

Permanent Address: ______________________________________ Apt. #: ____________

City: ______________________ State: ______________ Zip Code: ______________

Local Address: ______________________________________ Apt. #: ____________

City: ______________________ State: ______________ Zip Code: ______________

Home Phone Number: ______________________ Cell Phone Number: ______________________

Date of Birth: _____/_____/_____ Age: _______ Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Sex: ☐ Male ☐ Female Patient's Employer: ______________________________________

IN ORDER FOR US TO FAX YOUR RESULTS TO ANY OTHER PHYSICIANS TODAY WE MUST HAVE THE NAME AND FAX NUMBER SUPPLIED PRIOR TO THE PROCEDURE:

PHYSICIAN'S NAME: ______________________________ FAX#______________________

*** If you have more than one insurance company, please present both cards so that we may file with each in order to obtain maximum benefit on your behalf. ***

PRIMARY INSURANCE	**SECONDARY INSURANCE**
Insurance: ______________________	Insurance: ______________________
Policy / ID #: ______________________	Policy / ID #: ______________________
Group #: ______________________	Group #: ______________________
Insured's Name: ______________________	Insured's Name: ______________________
Relation to Patient: ______________________	Relation to Patient: ______________________

I have received a copy of the Privacy Policy and the Patient's Bill of Rights from my provider prior to my procedure date, and I have authorized the above person[s] who may receive my Protected Health Information. I may revoke this privilege at any time by giving written notification to this provider.

______________________________________ ______________
PATIENT'S SIGNATURE **DATE**