Advanced Gastroenterology PLLC
Advanced Endoscopy Center PLLC

KAISER PATIENT REGISTRATION

Please PRINT and fill out all information below.

Name (First, MI, Last): _____
Address: _____Apt:_____
City, State, Zip: _____

Gender: ☐ Male ☐ Female
Date of Birth:_____
SSN #: _____
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Primary Phone: (____)_____Type:_____
Secondary Phone: (___ _)_____ Type:_____

Email: _____

Ethnicity or Race:
□ Hispanic □ American Indian/Alaska Native
□ Native Hawaiian/Other Pacific Islander
□ Asian □ Black/African American □ Caucasian

Primary Care Doctor: _____

Patient Employment Information

☐ Employed ☐ Retired ☐ Unemployed ☐ Other
Employers Name: _____
Employers Phone: (____)_____

Insurance Information(If you are insured **through someone else**, please list their information below)

PrimaryIns: _____Secondary Ins: _____
ID #: _____ ID # _____
Group/Policy #: _____ Group/Policy #: _____
Subscriber's Name**: _____Subscriber's Name**: _____
Subscriber's DOB**: _____Subscriber's DOB**: _____
Relationship to Patient: _____ Relationship to Patient: _____

Please list below whom you authorize us to contact in case of an emergency or regarding your medical and billing information. *(Please list at least ONE contact)*

Name: _____ Phone: (____)_____Relationship to Patient:_____

Name: _____ Phone: (____)_____Relationship to Patient:_____

I attest that the information I have given here is correct and true to the best of my knowledge. I understand that I am responsible for keeping the doctor updated with current information regarding my account.

_____ _____
Patient/Guardian Signature Date