Digestive Health Associates of Reno

655 Sierra Rose Drive
Reno, Nevada 89511
Phone (775) 829-7600
Billing 1-866-978-6912
Fax (775) 829-3757
www.digestivehealthreno.com

HOW DID YOU HEAR ABOUT OUR PRACTICE?: ❑ REFERRAL ❑ PRIMARY CARE DOCTOR ❑ INTERNET ❑ MEDIA ❑ FRIEND

REFERRING PHYSICIAN _____ ACCOUNT # _____

PATIENT INFORMATION

Patient's Last Name: _____ First: _____ Initial: _____

Age: _____ Date of Birth: _____ Social Security #: _____

Address _____ City _____ State _____ Zip _____

Home Phone #: _____ Marital Status: ❑ Single ❑ Mar ❑ Div ❑ Sep ❑ Wid

Business Phone#: _____ Cell Phone #: _____

Patient's Email Address _____

Patient's Employer: _____ Occupation: _____

SPOUSE/GUARDIAN INFORMATION

IS YOUR SPOUSE/GUARDIAN CURRENTLY WORKING? ❑ YES ❑ NO RETIRED? ❑ YES ❑ NO

DOES PATIENT HAVE COVERAGE UNDER SPOUSE/GUARDIAN ❑ YES ❑ NO (IF YES, complete the following)

Last Name: _____ First: _____ Initial: _____

Date of Birth: _____ Social Security #: _____

INSURANCE INFORMATION

NOT CURRENTLY INSURED ❑

PRIMARY INSURANCE COVERAGE

Insured's Name: _____ Policy or Member ID# _____ Group #: _____

Insurance Company Name & Address: _____ Co-Pay Amount: _____

Employer: _____ Relationship to Patient: _____

SECONDARY INSURANCE COVERAGE

Insured's Name: _____ Policy or Member ID# _____ Group #: _____

Insurance Company Name & Address: _____

Employer: _____ Relationship to Patient: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION/INSURANCE BENEFITS

I authorize my insurance benefits to be paid directly to Digestive Health Associates/Digestive Health Center. I am financially responsible for any balance due. I authorize Digestive Health Associates/Digestive Health Center to release any information required for payment of this bill. A copy of this is as valid as the original. If my insurance requires a referral, I understand it is my responsibility to obtain this.

Signature: _____ Date: _____

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Acct#_____

PATIENT INFORMATION

DATE: _____

NAME: _____ DATE OF BIRTH: _____

RACE (Required)

- ☐ AMERICAN INDIAN OR ALASKA NATIVE
- ☐ ASIAN
- ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
- ☐ BLACK OR AFRICAN AMERICAN
- ☐ WHITE
- ☐ OTHER RACE _____
- ☐ DECLINED TO SPECIFY

ETHNICITY (Required)

- ☐ HISPANIC OR LATINO
- ☐ NOT HISPANIC OR LATINO
- ☐ DECLINED TO SPECIFY

PRIMARY LANGUAGE (Required)

- ☐ ENGLISH
- ☐ SPANISH
- ☐ OTHER _____
- ☐ DECLINED TO SPECIFY

SEXUAL ORIENTATION

- ☐ LESBIAN, GAY OR HOMOSEXUAL
- ☐ STRAIGHT OR HETEROSEXUAL
- ☐ BISEXUAL
- ☐ SOMETHING ELSE, PLEASE DESCRIBE _____
- ☐ DON'T KNOW
- ☐ DECLINED TO SPECIFY

GENDER IDENTITY

- ☐ IDENTIFIES AS MALE
- ☐ IDENTIFIES AS FEMALE
- ☐ FEMALE-TO-MALE (FTM) / TRANSGENDER MALE / TRANS MAN
- ☐ MALE-TO-FEMALE (MTF) / TRANSGENDER FEMALE / TRANS WOMAN
- ☐ GENDERQUEER, NEITHER EXCLUSIVELY MALE NOR FEMALE
- ☐ ADDITIONAL GENDER CATEGORY OR OTHER, PLEASE SPECIFY

_____

- ☐ DECLINED TO SPECIFY