GRANITE PEAKS GASTROENTEROLOGY

GRANITE PEAKS ENDOSCOPY

PATIENT DEMOGRAPHIC INFORMATION

Last Name Mouse	**First Name** Minnie
Middle Initial **Preferred/Nick Name**	**Social Security#**
Street—Apt/PO Box	**Date of Birth** **Gender**
City **State** **Zip**	**Email Address**
Home Phone ☐ Preferred Contact	**Cell Phone** ☐ Preferred Contact
Primary Care Doctor	**Referring Doctor**
Employer Name	**Employer Phone**
Emergency Contact Name	**Emergency Contact Phone**

OPTIONAL SECTION: Race & Ethnicity questions are asked to identify additional care of our diverse patient population and are not used to discriminate.

Race
- American Indian/Alaskan Native
- Asian/Pacific Islander
- African-American
- Hispanic/Latino
- White-Non Hispanic
- Other/Multi-Racial

Ethnicity:
- Hispanic or Latino
- Non-Hispanic or Latino
- Unknown
- Decline to specify

Marital Status
- Married
- Single
- Divorced
- Widowed
- Other

I Found Granite Peaks by:
- Website
- Facebook
- Advertisement
- Physician Referred
- Fam/Friend Referral

Preferred Language _____ **Translation Needed**

MEDICAL INFORMATION ACCESS

May we leave a message at your preferred contact phone with normal health results or information? **Yes** **No**

I consent to receive automated text and email messages for general communications. You may opt out of this service, by writing us, at any time.

Please list any individual we are authorized to speak with regarding your protected health information.

Name **Relationship**	**Phone**

Please list any individual we are authorized to speak with regarding your protected financial information.

Name **Relationship**	**Phone**

RESPONSIBLE/FINANCIAL PARTY (IF OTHER THAN PATIENT)

Full Name	**Date of Birth** **Phone**
Street	**City** **State** **Zip**

PATIENT INSURANCE INFORMATION

PLEASE PROVIDE INSURANCE CARD(S) AND PHOTO ID TO RECEPTIONIST

Primary Insurance	**Secondary Insurance**
Subscriber's Name (If other than patient)	**Subscriber's Name** (If other than patient)
Relationship to Patient	**Relationship to Patient**
Subscriber's Date of Birth	**Subscriber's Date of Birth**

Patient Signature _____ ***Date*** _____