OAKLAND COLON AND RECTAL ASSOCIATES, P.C Diseases of the Colon and Rectum

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WELCOME TO OUR OFFICE Today's Date: _____

Thank you for choosing our office. In order to serve you properly we will need the following Information.
(Please print). All information will be strictly confidential.

Patient's Name: _____ Birth Date: _____

Age: _____ Gender: Male___ Female____ Marital Status: Single ___ Married ___ Widowed___ Divorced___

Patient's Address: _____ _____
City State Zip

Home Phone Number_____ Business/Cell Number_____

Patient's Social Security Number_____ E: mail_____

Race: African American____ American Indian____ Asian____ Caucasian____ Native Hawaiian/Pacific Islander____ Other____

Ethnicity: _____ Preferred Language_____

Do you need an interpreter: Y N

Name of Spouse: _____ Spouse's Birth date: _____

Referring Physician: _____ Primary Care Physician_____

Patient's Occupation: _____

Name of Employer_____

Address of Employer_____

Pharmacy Information
Name (*ex: CVS, Rite Aid*) _____ Address_____

City_____ State_____ Zip_____ Phone_____

Mail Order ____Medco ____Express Scripts, Inc. ____Caremark

____PharmaCare ____Other_____

PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE CARD AND DRIVERS LICENSE TO COPY

I AUTHORIZE THIS OFFICE TO RELEASE ANY INFORMATION NECESSARY TO EXPEDITE INSURANCE CLAIMS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES REGARDLESS OF INSURANCE COVERAGE. FURTHERMORE, I AUTHORIZE THIS OFFICE TO RELATE OUR EVALUATION TO OTHER PHYSICIANS PROVIDING CARE TO ME THAT WILL ENHANCE CONTINUITY OF CARE.

Patient or Guardian Signature_____