DHI Digestive Health Institute
A Pinnacle GI Partner

Michigan Gastroenterology Institute & Capitol Colorectal Surgery

Patient Information

Patient Name ______________________ **Date of Birth** ____/____/____

Address ______________________
(Street) (City) (State) (Zip)

Phone #s ____________ ____________ ____________
(Home) (Cell) (Other)

Gender ☐ Male ☐ Female SS# ____________ Age ______ **Marital Status** ☐ S ☐ M ☐ W ☐ D

Patient's Occupation ____________ **Patient's Employer** ____________

Race ☐ Indian ☐ Asian ☐ African American ☐ Hawaiian Pacific ☐ Caucasian ☐ Other ☐ Decline to Answer

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Answer **Language Preferred** ____________

Email ______________________
If you provide your email address we will send you patient data via secured patient portal

Family Physician ____________ Phone ____________

Address ______________________
(Street) (City) (State) (Zip)

Referring Physician ____________ Phone ____________

Address ______________________
(Street) (City) (State) (Zip)

Primary Insurance ____________ Contract # ____________

Subscriber ____________ Subscriber Birth date ____/____/____

Employer ______________________

Secondary Insurance ____________ Contract # ____________

Subscriber ____________ Subscriber Birth date ____/____/____

Employer ______________________

Responsible Party ____________ SS# ____________

Address ____________ Phone ____________

Employer ____________ Work Phone ____________

Relationship to patient ☐ Self ☐ Spouse ☐ Child ☐ Other ____________

Emergency Contact (other than spouse) ____________ Phone ____________

COMPLETE THE FOLLOWING IF THE PATIENT IS A MINOR

Mother's Name ____________ Phone ____________

Father's Name ____________ Phone ____________

We bill and accept most insurance companies' usual and customary fees. You will be responsible for any deductible and co-pay amounts. Please ask our receptionist if you have any questions regarding your coverage.

I UNDERSTAND THAT UNDER THE HIPAA GUIDELINES, THAT MY INFORMATION MAY BE RELEASED TO OTHER PROVIDERS INVOLVED IN MY CARE FOR THE PURPOSES OF TREATMENT, PAYMENT, OR OPERATIONS. I AUTHORIZE THAT PAYMENT BE MADE DIRECTLY TO MICHIGAN GASTROENTEROLOGY INSTITUTE, TIN #38-3359571.
A COPY OF THIS SIGNATURE AND STATEMENT SHALL BE AS VALID AS THE ORIGINAL.

SIGNATURE REQUIRED

SIGNATURE ______________________ **DATE:** ____/____/____