Digestive Health Institute

1650 RAMBLEWOOD DR
EAST LANSING, MI 48823
P: (517) 332-1200 F: (517) 351-3327
www.michigangastro.com

1627 LAKE LANSING, SUITE 100
LANSING, MI 48912
P: (517) 372-0500 F: (517) 351-3327
www.capitolcolon.com

Iftiker Ahmad, M.D. ~ Oussama Al Sawas, M.D. ~Daniel C. Coffey, M.D. ~ Radoslav Coleski, M.D., PhD ~ Dorian Jones, M.D. ~ Lucas Julien, M.D. ~ Razvan Opreanu, M.D. ~ Scott Plaehn, D.O., FACOI ~Albert Ross, M.D. ~ Robert Rose, D.O., FACOI ~
Dana Stewart, D.O. ~ John Walling Jr., D.O., FACOI ~ David Wiedemer, M.D. ~ Siaka Yusuf, M.D.
Brooke Janke, PA-C ~ Michael Kosnik, PA-C ~ Donald Laird PA-C ~ Sabena M. Masood, PA-C ~ Jonathan Thelen PA-C ~
Rachael Wheelock, PA-C ~ Scott Zeilstra, PA-C

PATIENT NAME _____ BIRTHDATE _____

ADDRESS _____
(STREET) *(CITY)* *(ZIP)*
HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

GENDER: M F SOC. SECURITY # _____ MARITAL STATUS _____

PATIENT OCCCUPATION_____ PATIENT EMPLOYER_____
RACE(please circle): Indian Asian African American Hawaiian/Pacific Caucasian Other Race Declined
ETHNICITY (please circle): Hispanic or Latino Not Hispanic or Latino Declined
LANGUAGE _____

EMAIL:_____
If you provide your email address we will send you patient data via secured patient portal

FAMILY PHYSICIAN _____ PHONE : _____
ADDRESS _____
(STREET) *(CITY)* *(ZIP)*
REFERRING PHYSICIAN _____ PHONE _____
ADDRESS _____
(STREET) *(CITY)* *(ZIP)*
PRIMARY INSURANCE _____CONTRACT # _____
SUBSCRIBER _____ SUBSCRIBER BIRTHDATE _____
EMPLOYER _____

SECONDARY INSURANCE _____ CONTRACT # _____
SUBSCRIBER _____ SUBSCRIBER BIRTHDATE _____
EMPLOYER _____

RESPONSIBLE PARTY_____ SOC SEC#_____
ADDRESS _____ PHONE (_____) _____
EMPLOYER_____ WORK PHONE (_____) _____
RELATIONSHIP TO PATIENT_____

EMERGENCY CONTACT (Other than spouse) _____ PHONE _____

PLEASE 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 RECEPTIONISTS 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 _____ DATE _____