HERSHEY ENDOSCOPY CENTER PATIENT INFORMATION

The Pennsylvania Department of Health, the Pennsylvania Cost Containment Council, and the third-party payers (insurance companies) require that we obtain the following information.

PERSONAL INFORMATION:

Mr., Mrs., Ms._____
Name: Last First MI

Address:_____
Street City State Zip

Telephone (Home):_____Work:_____Cell:_____

Email Address:_____

Employer:_____

Date of Birth:_____

Relationship to Insured Party:_____ Marital Status (circle one): S M D W

Is it permitted to leave voice mail messages/send letters to your home? ___Yes ___ No
Is it permitted to leave a message with family members? ___Yes ___ No
Is it permitted to contact you at your work number? ___Yes ___ No
Is it permitted to leave voice mail messages at your workplace? ___Yes ___ No

Physician's Name:_____

Address:_____

Telephone:_____Fax:_____
Note* - For your records, any additional physicians may be included on the reverse side of this form.

EMERGENCY INFORMATION:

Name:_____Relationship:_____

Address:_____

Telephone (Home):_____Work:_____Cell:_____

Patient Signature:_____Date:_____

ADDITIONAL PHYSICIANS

1. **Physician's Name:**_____

   Address:_____

   Phone:_____ **Fax:**_____

2. **Physician's Name:**_____

   Address:_____

   Phone:_____ **Fax:**_____

3. **Physician's Name:**_____

   Address:_____

   Phone:_____ **Fax:**_____

4. **Physician's Name:**_____

   Address:_____

   Phone:_____ **Fax:**_____

5. **Physician's Name:**_____

   Address:_____

   Phone:_____ **Fax:**_____

6. **Physician's Name:**_____

   Address:_____

   Phone:_____ **Fax:**_____