

**USE BLACK INK ONLY**  
*OR BLUE*

**PLEASE COMPLETE FORM  
BRING TO PROCEDURE**

**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: \_\_\_\_\_

*↓  
over*

**ADDITIONAL PHYSICIANS**

1. Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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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: \_\_\_\_\_

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