

# EYVAZZADEH & REILLY COLON AND RECTAL CENTER

406 DELAWARE AVE. • BETHLEHEM, PA 18015 • 610-866-2600 • FAX: 610-861-7640 • www.ercrc.com

**PLEASE COMPLETE THE ATTACHED FORMS AND BRING THEM TO YOUR APPOINTMENT.  
ALSO, BRING YOUR INSURANCE CARD AND A VALID PHOTO ID.**

**Failure to provide our office with accurate and current insurance information may result in  
the patient being billed for the services rendered.**

## PATIENT INFORMATION SHEET

Date \_\_\_\_\_

Patient Name \_\_\_\_\_

Address \_\_\_\_\_

Email \_\_\_\_\_

Birth Date \_\_\_\_\_ Social Security # \_\_\_\_\_

Phone (Home) \_\_\_\_\_ Phone (work or cell) \_\_\_\_\_

Employer \_\_\_\_\_

Family Physician \_\_\_\_\_

### PRIMARY MEDICAL INSURANCE INFORMATION

Insurance Company's Name & Address \_\_\_\_\_  
\_\_\_\_\_

Patient ID # \_\_\_\_\_ Group # \_\_\_\_\_

#### If Policy Holder is other than patient:

Policy Holder's Name \_\_\_\_\_ Relation to Patient  Spouse  Other \_\_\_\_\_

Policy Holder's ID# \_\_\_\_\_ Policy Holder's DOB \_\_\_\_\_

Policy Holder's Employer \_\_\_\_\_

### SECONDARY MEDICAL INSURANCE INFORMATION (if applicable)

Insurance Company's Name & Address \_\_\_\_\_  
\_\_\_\_\_

Patient ID # \_\_\_\_\_ Group # \_\_\_\_\_

#### If Policy Holder is other than patient:

Policy Holder's Name \_\_\_\_\_ Relation to Patient  Spouse  Other \_\_\_\_\_

Policy Holder's ID# \_\_\_\_\_ Policy Holder's DOB \_\_\_\_\_

Policy Holder's Employer \_\_\_\_\_