

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 _____