EYVAZZADEH & REILLY COLON AND RECTAL CENTER

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

Prior to your procedure, mail the completed forms, the front and back of insurance cards and a valid photo ID to 406 Delaware Ave., Bethlehem, PA 18015.

If your procedure is scheduled at the hospital, please bring the completed "Outpatient Admission Summary Form" with you to the hospital on the day of the procedure.

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 _____