REGISTRATION FORM NORTH TEXAS GASTROINTESTINAL ASSOCIATES SHAWN W. PANZER M.D.

Section I:
Patient Information **Today's Date**_____

Name:_____
Address:_____ Apt or Lot:_____
City:_____ State:_____ Zip_____
Phone (_____)_____ Work Phone (_____) _____
Cell Phone (_____)_____ Email_____
Date of Birth:__/___/____ Social Security Number:____-____-_____
Primary Care Provider/Current Doctor:_____
Employer Name:_____ ☐ FT ☐ PT ☐ Retired
Check Appropriate Box:☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
If Student ☐ FT ☐ PT

Section II **Insurance Information**

Primary Insurance Company Name_____
Network Name (if applicable)_____ _____
ID#_____ Group #_____ Employer _____
Name of Primary Insured_____ DOB __/___/_____
Relationship to Insured _____ SSN#:____-_____-_____

---------- DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No

IF YES, COMPLETE THE FOLLOWING ----------

Secondary Insurance Company Name_____
Network Name (if applicable)_____
ID#_____ Group #_____ Employer _____
Name of Primary Insured_____ DOB __/___/_____
Relationship to Insured _____ SSN#:____-_____-_____

Tertiary Insurance Company Name _____
Network Name (if applicable)_____
ID#_____ Group #_____ Employer _____
Name of Primary Insured_____ DOB __/___/_____
Relationship to Insured _____ SSN#:____-_____-_____