California Digestive Disease Center

Fresno Endoscopy Center

7405 N Fresno Street ▪ Fresno CA 93720
Tel: (559)438-8400 ▪ Fax: (559)438-0477

Patient Registration Form

First Name:	**Middle Name**	**Last Name**

Date of Birth	**Gender**	**Social Security #**
Physical Address	**City**	**City/Zip**
Home/Cell Phone	**Work Phone**	**Email Address**
Employer Name	**Address**	**Occupation**

Personal Information

RACE: American Indian/Alaska Native Asian Black/African American Hispanic Pacific Islander Caucasian

other: _____ more than once race: _____

Marital Status: Single Married Divorced Widow/Widower Common Law

Spouse Name: _____ DOB: _____SS#: _____

Phone Number: _____ Cell Number: _____

Emergency Contact

Name	Phone	Relation

Authorization & Acknowledgements: Your initials Indicate Consent

Privacy	_____	**I □ Do □ Do Not** authorize Ujagger S Dhillon, Dr Jaya Krishna Chintanaboina M.D. and Fresno Endoscopy Center to discuss my appointments, medical evaluation, treatment and results to relatives or other person indicated: Please list Authorized Person/Relationship 1. _____2. _____
Living Will	_____	I acknowledge that I am aware of the need for Advance Directives and that I understand information is available if needed. I also acknowledge that **I □ Do □ Do Not** have Advance Directives (either a living Will or a Durable Power of Attorney for Healthcare.) if I do not have such Advance Directives at this time, but establish them at a later date I will provide the office with a copy.
Transfer	_____	In case of an emergency California Digestive Disease Center or Fresno Endoscopy Center, I understand that I will be transferred to the nearest hospital emergency room.

Assignment of Benefits

To assist in the processing of my insurance claim. Kindly furnish my insurance company with any information you may have regarding my condition while under your treatment. I authorize payment of benefits directly to Dr. Ujagger S. Dhillon or Fresno Endoscopy Center, for service described. I accept full financial responsibility for services rendered. I authorize payment of medical benefits to the physician for services rendered.

Patient Signature_____ Date_____
Legal /Authorized person signature