

Norman Endoscopy Center Patient Registration Information

Date of Procedure: _____ **NEC Physician:** _____
Time of Procedure: _____ **Primary Care Physician:** _____

Patient Name: _____, _____
(last name) (first name) (middle initial) (suffix)

Mailing Address: _____
(street address) (state) (zip code)

Telephone: _____ (home) **Emergency Contact:** _____
_____ (cell) **Emergency Contact telephone:** _____
_____ (work) **Email Address:** _____

Date of Birth: _____

Gender: ☐ male ☐ female ☐ other _____

Do you have any Hispanic origin? ☐ yes ☐ no ☐ unknown

Marital Status: ☐ single ☐ married ☐ widowed ☐ divorced ☐ life partner

Insurance Information (please bring insurance cards to appointment)

Primary Insurance:	Secondary Insurance:
Subscriber ID:	Subscriber ID:
Group Number:	Group Number:
Policy Holder's Name:	Policy Holder's Name:
Relationship to the patient:	Relationship to the patient:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:

Co-pays and deductibles will be due on the day of service. As a courtesy, Norman Endoscopy Center will bill your insurance company(s). You will be billed for the amount not paid by your insurance company. If you do not have insurance coverage please call the business office at 405-366-0969 to determine payment options.

Please Note: Norman Endoscopy Center and the physician's offices are separate entities and will bill you separately. The anesthesia provider will send an invoice for their services. If a polyp is removed or tissue is taken during your procedure you will incur two pathology charges: one from company that preps your specimen onto slides and the other from a pathologist who analyzes and reports findings to your physician.

If you have any questions, please do not hesitate to call: 405-366-0969

Please mail or fax this Registration Packet to:

***NORMAN ENDOSCOPY CENTER
1515 N. Porter Suite 100
Norman, OK 73071
Fax: 405-701-3734***