Comprehensive Digestive Health, PLLC
Khaled Elraie, MD, FACG

Registration Form

Last name	First	MI	Jr., Sr.

Home phone		email

Address

Date of birth	Age	SSN	Marital Status

Occupation	Employer

Work address	Work phone

Insurance Information

Insured home address

Insured home phone	Insured email

Insured date of birth	Insured SSN

Insured Occupation	Insured Employer

Insured employer address

Primary Insurance company

Group ID (if applicable)	ID (if applicable)

Secondary Insurance Information	
Secondary Insurance company	
Group ID (if applicable)	**ID (if applicable)**

Financial Responsibility and Assignment of Insurance Benefits

I guarantee payment to Comprehensive Digestive Health for the services provided to the patient. I understand I am personally responsible for all charges not covered by insurance. I authorize payment of surgical and medical benefits, which would otherwise be payable to me, to Comprehensive Digestive Health for medical services rendered. If covered by Medicare or Medicaid, I certify the information provided by me is correct.

Consent for Healthcare and Release of Medical Information

I voluntarily consent to healthcare treatment from the physician and staff at this facility. I consent to any necessary lab work. I am aware theat the practice of medicine is not an exact science. No guarantees have been made to me regarding the result of treatment or examination by my caregivers. I consent to the use and disclosure of protected health information about me for treatment, payment and healthcare operations. I have read this form. I have had the opportunity to ask questions and my questions have been answered.

Signed Date