Please fill out the following information to be scheduled for a colonoscopy at Evergreen Endoscopy Center, LLC. Once received, a scheduling nurse will contact you to review the information and provide you with further instructions.

DEMOGRAPHIC DATA

LAST NAME_____ **FIRST NAME**_____**M.I.** _____

SUFFIX (JR, SR, ETC)_____ **GENDER** M/F **MARITAL STATUS** S/M/D/W/O

DATE OF BIRTH (MM/DD/YYYY)_____/_____/_____ **SS #** _____-____-_____

STREET ADDRESS_____

CITY_____ **STATE**_____ **ZIP** _____

PHONE: Please check preferred contact #

( )HOME: _____ **( )CELL:**_____ **( )WK:**_____

PRIMARY CARE PHYSICIAN _____

PHARMACY_____ **TEL#:**_____

INSURANCE INFORMATION

PRIMARY INSURANCE

Company_____

ID# _____

Group # _____

Policyholder _____

Relationship _____ **DOB**_____

Provider line/Customer Service Tel#

_____

SECONDARY INSURANCE

Company_____

ID# _____

Group # _____

Policyholder _____

Relationship _____**DOB**_____

Provider line/Customer Service Tel #

_____

PROCEDURE DATA

REASON: ( ) SCREENING **( )** HISTORY OF POLYPS **( )** FAMILY HISTORY OF COLON CANCER

DATE OF LAST COLONOSCOPY_____ **WHERE ?**_____

PREFERRED PHYSICIAN ( ) DR AYERS **( )** DR BROWN **( )** DR LEWIS **( )** DR MULLINS

( ) DR BANERJEE **( )** DR SKOPIC **( )** DR HEMACHA **( )** DR QURESHI **( )** DR KOKKAT

( ) I PREFER A FEMALE PHYSICIAN **( )** I DO NOT HAVE A PREFERENCE OF PHYSICIAN