KASSAMO DAYEMO, M.D.
Gastroenterology
Board Certified

Digestive and Liver Disease Care
1606 Ashley River Road ▪ Charleston, SC 29407
(843) 763-0503 ▪ (843) 763-0514 FAX

PATIENT REGISTRATION

NAME: **DATE OF BIRTH:**

MAILING ADDRESS: **CITY:**

STATE, ZIP CODE:

MARITAL STATUS: ( )Divorce ( )Legally Separated ( )Married ( )Single ( )Widowed ( )Unknown

RACE: ( )American Indian or Alaskan Native ( )Asian ( )Black ( )Caucasian ( )Pacific Islander ( )Other ( )Declined

ETHNICITY: ( )Hispanic ( )Non-Hispanic ( )Declined

LANGUAGE: ( )English ( ) Spanish ( )Other, please specify: _____

SSN: **DRIVER'S LICENSE:** **REFERRED BY:**

Email :

PHONE #: HOME ( ) **WORK ( )** **EMPLOYED BY:**

FULL TIME: ( ) **PART TIME: ( )**

SPOUSE'S NAME: **DATE OF BIRTH:**

EMERGENCY CONTACT: **Phone#::** **RELATION**

ADDRESS:

INSURANCE AND BILLING INFORMATION:

PAYMENT REQUIRED AT THE TIME OF SERVICE-UNLESS PRIOR ARRANGEMNTS HAVE BEEN MADE:

1. INSURANCE COMPANY: **ADDRESS:**

NAME OF INSURED: **RELATIONSHIP TO PATIENT:** **GROUP #:**

2. INSURANCE COMPANY: **ADDRESS:**

NAME OF INSURED **RELATIONSHIP TO PATIENT:** **GROUP #:**

For Tricare patients please complete the following:

TRICARE PRIME: ( ) **TRICARE FOR LIFE: ( )** **TRICARE STANDARD: ( )**

( ) Active Duty **Army ( )** **Navy ( )**
( ) Retired **Marine ( )** **Air Force ( )**

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment to Dr. **Kassamo Dayemo MD** for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.

PATIENT NAME: (please print) _____ DATE: _____

SIGNATURE: _____