

PATIENT INFORMATION

PLEASE PRINT

LAST NAME: _____ FIRST NAME: _____ MIDDLE: _____

SSN: _____ BIRTH DATE: _____

ADDRESS: _____ HOME PHONE: _____

CITY: _____ WORK PHONE: _____

STATE: _____ EMPLOYER: _____

ZIP: _____ CELL PHONE: _____

PATIENT'S EMAIL ADDRESS

SEX: FEMALE MALE MARITAL STATUS: _____

REFERRING DR: _____ PRIMARY DOCTOR: _____

Last name

First Name

Last Name

First Name

PERSON TO CONTACT IN AN EMERGENCY: _____

Name

Phone number

PRIMARY INSURANCE IS PROVIDED BY: PATIENT SPOUSE PARENT

SPOUSE/PARENT INFORMATION

SPOUSE/PARENT NAME: _____

SPOUSE/PARENT ADDRESS: _____ PHONE: _____

SPOUSE/PARENT EMPLOYER: _____

SPOUSE/PARENT DATE OF BIRTH: _____ SSN: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Gastroenterology Associates, P.C. to furnish information to insurance carriers concerning my illness and treatments. I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. By providing us with your wireless/cellphone number, you are hereby granting us, and our agents or independent contractors, your consent to receive calls on your wireless/cellphone number for billing and debt collection purposes.

I understand that it is my responsibility to obtain all procedure precertification and second opinion appointments and that I am responsible for any and all amounts not covered by my insurance carrier(s).

SIGNATURE: _____ DATE: _____

Patient signature or POA signature

Relationship to patient(if patient did not sign) _____ POA papers received