# PATIENT INFORMATION

**PLEASE PRINT**

Last Name: First Name: MI:

Birth Date: [ ]Male [ ]Female SSN:

Marital Status:

Address: Mailing address if different

City:

State: ZipCode

Email: Can we email you appt info [ ] Yes [ ] No

Referring Dr: Primary Doctor:

Last name First name Last name First name

Home Phone: Employer:

Cell Phone: Work Phone:

Emergency Contact:

Name Relationship Phone Number

Primary Insurance is provided by: ☐PATIENT ☐SPOUSE ☐PARENT

## SPOUSE/PARENT INFORMATION (if they provide your insurance)

Spouse/Parent Name that provides the insurance:

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 ☐