PATIENT INFORMATION

PLEASE PRINT

LAST NAME: FIRST NAME: MIDDLE:

SSN: BIRTH DATE:

HOME PHONE: EMPLOYER:

CELL PHONE: WORK PHONE:

ADDRESS: MAILING ADDRESS:

CITY: CITY:

STATE: ZIP STATE: ZIP:

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 ☐