Gastroenterology Specialists

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PATIENT INFORMATION

PLEASE PRINT Date _____

Patient's Name _____ ( ) Male ( ) Female
(Last) (First) (Middle Initial)

Address _____
(Street) (Apt #) (City) (State) (Zip)

Home Phone # ( )_____Cell # ( )_____ Marital Status _____ Language_____

Date of Birth _____ Race _____ Ethnicity _____ Social Security # _____

Employer_____ Occupation_____

Preferred Method of Communication ☐ Paper ☐ Phone ☐ Portal/Secure Messaging ☐ Email_____

In Case of Emergency Contact _____
(Please provide the name, phone number and relationship of someone not at your address)

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Primary Insurance Company Name _____ ( ) HMO ( ) PPO

Primary Card Holder Name_____
(Last) (First) (Middle Initial)

Date of Birth _____ Soc Sec # _____ Relationship to Patient _____

Employer _____ Phone ( )_____

Secondary Insurance Company Name _____ ( )HMO ( ) PPO

Primary Card Holder Name_____
(Last) (First) (Middle Initial)

Date of Birth _____ Soc Sec # _____ Relationship to Patient _____

Employer _____ Phone ( )_____

Person responsible for patient's account (if different from patient) _____
(Name)

I authorize Gastroenterology Specialists to furnish my insurance company with any information necessary from the patient's medical records. I also authorize payment of surgical and/or medical benefits directly to Gastroenterology Specialists. I understand that I am financially responsible for charges not covered by my insurance.

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(Signature)

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MEDICARE PATIENTS ONLY: I request that payment of authorized MEDIGAP benefits be made on my behalf to Gastroenterology Specialists for any services provided to me. I authorize any holder of medical information about me to release to my MEDIGAP company any information needed to determine these benefits.

_____
(Signature)

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