Doctor: ____________

PATIENT INFORMATION

Name: ____________

Address: ____________

____

City,State, Zip: ____________

Home Phone: ____________

Work Phone: ____________

Mobile/Pager Phone: ____________

Patient ID #: ____________ Sex: [ ]M [ ]F

Date of Birth: ____________ Age: ____________

Driver's License #: ____________

Social Security #: ____________

Marital Status: [ ]Married [ ]Single [ ]Divorced [ ]Widowed

Referring Physican: ____________

Primary Physician: ____________

PATIENT EMPLOYMENT INFORMATION

[ ]Employed [ ]Retired [ ]Unemployed [ ]Other

Employer's Name: ____________

Employer's Phone: ____________

Occupation: ____________

EMERGENCY CONTACT

Name ____________

Relationship ____________

Phone ____________

RESPONSIBLE PARTY

Name: ____________

Address: ____________

____

City,State, Zip: ____________

Employer: ____________

Home Phone: ____________

Work Phone: ____________

SSN: ____________

Date of Birth: ____________

PRIMARY INSURANCE

Insurance Company Name: ____________

ID #: ____________

Group/Policy #: ____________

Subscriber's Name: ____________

Subscriber's Phone #: ____________

Relationship to Patient: ____________

Subscriber's Employer: ____________

Subscriber's SS #: ____________

Subscriber's Date of Birth: ____________

SECONDARY INSURANCE

Insurance Company Name: ____________

ID #: ____________

Group/Policy #: ____________

Subscriber's Name: ____________

Subscriber's Phone #: ____________

Relationship to Patient: ____________

Subscriber's Employer: ____________

Subscriber's SS #: ____________

Subscriber's Date of Birth: ____________

WORK RELATED INJURY

Only applicable if injury is related to work or auto accident

Insurance Carrier Name: ____________ Address: ____________

City, State, & Zip: ____________ Phone: ____________

Claim Number: ____________ Date of Injury: ____________ Employer @ time of Injury: ____________

I hereby authorize payment directly to Gastroenterology Associates all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance, for all services rendered on my behalf. I authorize the above noted and/or any provider or supplier of services in this office to release any information required to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

____________________________ ____________________________

Guardian's Signature (if patient is 18) DATE Patient's Signature DATE