

## Patient Information

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_

Address \_\_\_\_\_ City/State/ZIP \_\_\_\_\_

Cell phone # \_\_\_\_\_ Home phone # \_\_\_\_\_ Work phone # \_\_\_\_\_

SSN \_\_\_\_\_ Married \_\_\_\_\_ Single \_\_\_\_\_ Widowed \_\_\_\_\_ Divorced \_\_\_\_\_ Other \_\_\_\_\_

Email address \_\_\_\_\_ Do we have your permission to contact you via email regarding test results or follow-up plans?  Yes  No

Employed by \_\_\_\_\_ How long? \_\_\_\_\_ Occupation \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Occupation \_\_\_\_\_

Employed by \_\_\_\_\_ Spouse's work phone # \_\_\_\_\_

Emergency contact (not living with you) \_\_\_\_\_ Phone # \_\_\_\_\_

Primary care provider/Family Physician \_\_\_\_\_

**How did you hear about our practice?**

- |  |  |
|--|--|
| <input type="checkbox"/> Physician (name _____)  | <input type="checkbox"/> Word of Mouth     |
| <input type="checkbox"/> Yellow pages  | <input type="checkbox"/> Insurance company |
| <input type="checkbox"/> Internet ( <input type="checkbox"/> search engine <input type="checkbox"/> Dex online/DexKnows.com) | <input type="checkbox"/> Other _____       |

Primary Insurance \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Name of Insured\* \_\_\_\_\_ Relationship \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Name of Insured\* \_\_\_\_\_ Relationship \_\_\_\_\_

\* Note: If insured is someone other than patient (such as spouse or parent), we need that person's date of birth \_\_\_\_\_ and social security # \_\_\_\_\_ in order to bill insurance.

I authorize Gastroenterology Associates, P.C., to furnish my insurance carrier(s) with all pertinent information and records that may be necessary to process my claim(s). I authorize benefits under any insurance claim to be paid directly to Gastroenterology Associates, P.C. I guarantee payment of any amount due the Physician not covered by this assignment of Insurance Benefits. I agree to pay this account in full or pay 18% APR on any unpaid balance over 30 days. I also agree to pay any legal fees or court costs associated with the collection of this account should it become outstanding for more than ninety (90) days from the date of service.

Signature \_\_\_\_\_ Date \_\_\_\_\_