

Affiliates in Gastroenterology

Today's Date _____

Patient Information

Name: Last _____ First: _____ Middle: _____

Address _____ City,State,Zip _____

Phone: Home _____ Work _____ Ext _____

Birthdate _____ Social Security # _____

Sex: M F Place of Birth _____ Marital Status: Single Married Widow Divorced Separated

Occupation _____ Employer _____

Referring or Family Physician _____

Emergency Contact Information

Name _____ Phone # _____

Relationship _____ Alternate Phone # _____

Responsible Party Information, If Other Than Patient

Responsible Party _____ Relationship to Patient _____

Address _____ City,State,Zip _____

Phone: Home _____ Work _____ Ext _____

Insurance Information - MUST BE COMPLETED IN ITS ENTIRETY

Primary Insurance _____ Group # _____

Address _____ ID# _____

Subscriber _____ Subscriber's Birthdate _____

Insurance Phone # _____

Employer _____

Do you require a referral from your PCP? _____

Secondary Insurance _____ Group # _____

Address _____ ID# _____

Subscriber _____ Subscriber's Birthdate _____

Insurance Phone # _____

Employer _____

Do you require a referral from your PCP? _____

Please complete reverse side of this form. Signatures are required.

Designation of Certain Relatives, Close Friends and Other Caregivers

I agree that Affiliates in Gastroenterology, P. A. may disclose certain health information to a family member, close personal friend or other caregiver because such person is involved with my health care or payment relating to my health care. In that case, Affiliates in Gastroenterology will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care. I designate the following persons as persons involved with my health care or payment relating to my health care for the purpose of Affiliates in Gastroenterology, P. A. making the limited disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.

Print name(s) and date of birth _____

The staff and/or physicians of Affiliates in Gastroenterology, P. A. may need to contact you regarding appointments, results of tests, return phone calls, etc.

How May We Contact You (other than home phone #)

Cell Phone: Yes No If yes, Phone # _____ May we leave a message in voice mail? Yes No

Work Phone: Yes No If yes, Phone # _____ May we leave a message in voice mail? Yes No

e-mail: Yes No If yes, e-mail address _____

With whom may we leave a message for you to contact this office? (Please list name and relationship to you)

Do you have any other instructions?

I request that payment of authorized insurance benefits be made to Affiliates in Gastroenterology for services provided to me by the provider. I authorize the release to any referring physician or appropriate insurance company any medical information acquired in the course of my examination or treatment. I understand that I am financially responsible for any co-pay, deductible, co-insurance and non-covered expenses.

Signature _____

Notice of Privacy Practices

I acknowledge that the **Notice of Privacy Practices** from Affiliates in Gastroenterology was available to me.

Signature _____