

**GASTROENTEROLOGY ASSOCIATES, P.C.**

**PATIENT INFORMATION FORM**

DATE: \_\_\_\_\_

NAME: \_\_\_\_\_

BIRTH DATE: \_\_\_\_\_ MALE \_\_\_\_\_ FEMALE \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

(Parent's if patient is a minor)

PARENT/GUARDIAN NAME & S.S.# \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ PHONE: \_\_\_\_\_

CHECK ALL THAT APPLY: Single \_\_\_\_\_ Married \_\_\_\_\_ Widow(er) \_\_\_\_\_ Student \_\_\_\_\_

RACE: (circle one) White/Caucasian African American Spanish/Hispanic Asian Other

PREFERRED LANGUAGE: (circle one) English Spanish Other

Spouse: Name \_\_\_\_\_ Employer: \_\_\_\_\_ Work #: \_\_\_\_\_

Name of Primary Care Physician: \_\_\_\_\_

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**INSURANCE INFORMATION: PLEASE ALLOW US TO PHOTOCOPY YOUR INSURANCE CARD(S)**

Patient's Relationship to Insured: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other \_\_\_\_\_

PRIMARY INSURANCE: \_\_\_\_\_ SECONDARY: \_\_\_\_\_

Insured's Name if Other Than Self: \_\_\_\_\_ Insured's Date of birth: \_\_\_\_\_

Insured's Address if Different Than Above: \_\_\_\_\_

Insured's SS# \_\_\_\_\_ Insured's Sex: Male \_\_\_\_\_ Female \_\_\_\_\_