

**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 \_\_\_\_\_

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

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

Preferred Pharmacy \_\_\_\_\_

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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 S.S. # \_\_\_\_\_

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

Insured's Birth date \_\_\_\_\_ Insured's Sex: Male \_\_\_\_\_ Female \_\_\_\_\_

**MEDICARE PATIENTS - PLEASE COMPLETE BELOW**

The practice accepts assignment on all Medicare claims. However, any co-payment, deductible or non-covered service is your responsibility and we ask that you pay this at the time of your visit.

**PATIENT'S MEDICARE AUTHORIZATION: (MEDICARE PATIENTS ONLY)**

I request that payment of authorized Medicare benefits be made to me or on my behalf to the practice of Gastroenterology Associates, P.C. I authorize the practice of Gastroenterology Associates, P.C., to release to the Health Care Financing Administration, and its agents, that information needed to determine these benefits or the benefits payable for related services.

I understand my signature requests that payment be made, and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 on the HCFA-1500 form, or on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insured or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the payment determination of the Medicare carrier as the full payment and the patient is responsible only for their deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

SIGNED: \_\_\_\_\_

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