Affiliates in Gastroenterology, P. A.

Today's Date_____

Patient Information

MRN #_____(office use only)

Name: Last_____ First:_____ Middle:_____

Address_____ City,State,Zip_____

How may we contact you? Home Phone: Yes No_____ Cell Phone: Yes No _____

Work Phone: Yes No _____May we leave a message? Home - Yes No, Cell - Yes No, Work - Yes No

Birthdate_____Social Security #_____E-mail_____

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

Occupation_____ Employer_____

Referring or Family Physician_____

Pharmacy_____ Pharmacy Phone #_____

Emergency Contact Information

Name_____ Phone #_____

Relationship_____ Other Phone #_____

Responsible Party Information, If Other Than Patient

Responsible Party_____ Relationship to Patient_____

Address_____ City,State,Zip_____

Phone #_____ Other Phone #_____

Insurance Information - MUST BE COMPLETED IN ITS ENTIRETY

Primary Insurance_____ Group #_____

Address_____ ID#_____

Subscriber_____ Subscriber's Birthdate_____

Insurance Phone #_____ Do you require a referral from your PCP? Yes No

Employer_____

Secondary Insurance_____ Group #_____

Address_____ ID#_____

Subscriber_____ Subscriber's Birthdate_____

Insurance Phone #_____

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 Gastroenterolgy, 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_____

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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.

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

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Do you have any other instructions?

_____

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I request that payment of authorized insurance benefits be made to Affiliates in Gastroenterolgy 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_____