GASTROENTEROLOGY CONSULTANTS, P.C.

Patient Name (LAST):_____ (FIRST)_____ (MI)_____

Address:_____ City:_____ Zip:_____

Telephone Number: ( )_____Date of Birth:_____

Work contact phone number ( ) _____ Cell phone ( ) _____

E-mail address (optional) _____ Circle one: MALE FEMALE

Marital Status: ___Married ___Single ___Widowed ___Divorced ___Partnered

Patient Employer:_____ Telephone: ( )_____

If Minor, List Parent or Guardian Name:_____

Person (not living with you) to call in case of emergency_____Phone ( )_____

Spouse Name:_____ Spouse Date of Birth: ___

Address: _____ Phone ( ) _____

Primary Insurance Co. (*Please list both name and address*):_____

_____

Policy Holder Name:_____ ID#:_____ Grp#:_____

Secondary Insurance Co. *(Please list both name and address)*:_____

_____

Policy Holder Name:_____ ID#:_____ Grp#:_____

Referring Physician:_____Telephone ( )_____

Primary Care Physician:_____Telephone ( )_____

INSURANCE AUTHORIZATION/ASSIGNMENT:

I hereby authorize **Gastroenterology Consultants, P.C.** to release necessary information to insurance carriers acquired in the course of my treatment.

Signature:_____ Date:_____

I hereby assign payment of medical benefits for me or my dependent(s) to **Gastroenterology Consultants, P.C.**

Signature:_____ Date:_____