

Gastroenterology Associates, P.C.
Patient Information Form

Please print all information in the spaces provided. Be sure to complete and sign the statement on the bottom of this form.

Patient Information

Last Name _____ First Name _____ M.I. _____

Home Address _____ City _____

State _____ Zip Code _____ Phone # _____ Cell # _____

Employer Name, Address & Work Phone # _____

Social Security Number _____ Date of Birth _____

Emergency Contact Name & Phone Number _____

Referring Physician Name & Address _____

Primary Insurance

Company Name & Phone Number _____

Billing Address _____

Name of Insured _____ Relation to Patient _____

Insured's Date of Birth _____ Insured's Social Security # _____

Insured's ID Number _____ Group Number _____

Insured's Address _____ Insured's Phone # _____

Secondary Insurance

Company Name & Phone Number _____

Billing Address _____

Name of Insured _____ Relation to Patient _____

Insured's Date of Birth _____ Insured's Social Security # _____

Insured's ID Number _____ Group Number _____

Insured's Address _____ Insured's Phone # _____

I hereby authorize payment of medical benefits billed to my insurance to *Gastroenterology Associates, PC*. I hereby accept responsibility for payment for any services(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance, if the Practice does not participate with my insurance.

I agree to pay all copayments, coinsurance, and deductibles at the time the service is rendered.

I will pay by (check one) cash check credit card

Signature of patient or guardian

Date