

CONSULTANTS IN GASTROENTEROLOGY, INC.

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PATIENT INFORMATION

NAME: \_\_\_\_\_ SOCIAL SECURITY#: \_\_\_\_\_

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

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK or CELL PHONE: \_\_\_\_\_

SEX: M \_\_\_\_\_ F \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

NAME OF PARENT or SPOUSE: \_\_\_\_\_

PHARMACY: \_\_\_\_\_ PHARMACY PHONE: \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_

EMERGENCY NOTIFICATION

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

HEALTH INSURANCE

PRIMARY INSURANCE PLAN NAME: \_\_\_\_\_

INSURANCE ID #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

POLICY HOLDER NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

SECONDARY INS: \_\_\_\_\_ ID #: \_\_\_\_\_

ASSIGNMENT OF BENEFITS: I hereby assign payment of authorized Medicare benefits and/or any other medical and/or surgical benefits, to include Major Medical benefits to which I am entitled, to be made on my behalf to CONSULTANTS IN GASTROENTEROLOGY, INC. for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release any information needed to determine these benefits payable for related services.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

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

SIGNATURE OF \_\_\_\_\_ DATE: \_\_\_\_\_

RESPONSIBLE PARTY (if minor): \_\_\_\_\_