

PATIENT INFORMATION

Patient Account # _____

Name: _____ Date Of Birth ____ - ____ - ____ Age: ____ Sex: ____

Social Security# ____ - ____ - ____ Drivers License # _____ State _____

Address: _____ () _____ () _____
Street City Zip home phone cell phone

Employed By: _____ () _____
Company Occupation business phone

Street Address City Zip

Marital Status: Single Married Divorced Widowed E-MAIL Address: _____

Spouse's Name: _____ Social Security # ____ - ____ - ____

Employed By: _____ () _____
Company Occupation Business Phone

Street City Zip

Person to Notify In Case of Emergency And/Or Release of Medical Information
Name Relationship Phone#

Primary Insurance: _____ Insured's ID# _____

Address phone #

Insured's Name _____ Patient's Name: _____

Patient's Relationship to Insured: Self Spouse Child Other ****Spouse's Date of Birth** ____ - ____ - ____

Insured's Policy or Group # _____

Secondary Insurance: _____ Insured's I.D. _____

Insured's Name _____ Insured's Policy or Group _____

Is Patient's Condition Related to Employment? Yes No

Is There Another Health Benefit Plan? Yes No

I hereby state that the above information is true and correct. I hereby authorize Bay Area Gastroenterology, PA to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I hereby authorize payment of medical benefits billed to my insurance to Bay Area Gastroenterology, PA. I hereby accept responsibility for payment for any service(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 co-payments, coinsurance, and deductibles at the time the service is rendered unless other arrangements are made.

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

Signature of patient or guardian

date