GASTROENTEROLOGY ASSOCIATES

Please help us to serve you better by taking a few minutes to provide the following information.

PATIENT INFORMATION

Social Security Number: _____

Title: _____ Last Name: _____ First Name: _____ MI: ____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Date of Birth: _____

Sex: _____ Family Doctor: _____

E-mail address: _____

[ ] I decline to answer the following questions: **Preferred Language:** _____

Ethnicity: [ ] Hispanic Origin [ ] Non-Hispanic Origin [ ] Unknown

Race: [ ] Am. Indian [ ] Asian [ ] Black [ ] Native Hawaiian [ ] Unknown [ ] White

Pharmacy Name: _____ **Pharm. Location**: _____

Next of Kin (Name): _____ Phone: _____ Relationship: _____

Marital: [ ] S-Single [ ] M-Married [ ] D-Divorced [ ] W-Widowed [ ] X-Separated

FINANCIALLY RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

Social Security Number: _____ Date of Birth: _____

Last Name: _____ First Name: _____

INSURANCE

Primary Insurance Co.: _____ Policy #: _____

Secondary Insurance Co.: _____ Policy #: _____

I authorize the release of any medical or other information necessary to process insurance claims:

Signed: _____ Date: _____

I authorize payment of medical benefits directly to this practice for the services rendered.

Signed: _____ Date: _____