



Date of Visit: \_\_\_\_\_

### Patient Information

New Patient

Update

Name: Mr./Mrs./Ms. \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_  
Street City State Zip

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Ethnic Origin:  White  Black/African-American  American Indian/Alaska Native  Asian  Hispanic  
 Native Hawaiian/Pacific Islander  Multi Racial  Refuse/Unknown  Other

Religious Preference: \_\_\_\_\_

Home Phone: ( ) Cell Phone: ( ) Work Phone: ( )

e-mail address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
Street City State Zip

Marital Status: \_\_\_\_\_ Spouse: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: ( )

In Case of Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_

Home Phone: ( ) Cell Phone: ( ) Work Phone: ( )

Referring Physician: \_\_\_\_\_ Is this a Worker's Comp Claim?  Yes  No  
Address: \_\_\_\_\_

### Medical Insurance Information

Primary Insurance Company: \_\_\_\_\_ Telephone: ( )

Policy Number: \_\_\_\_\_ Certificate Number: \_\_\_\_\_

Group Number: \_\_\_\_\_ Policyholder: \_\_\_\_\_ Relationship to Policyholder: \_\_\_\_\_

Policy Holder Date of Birth: \_\_\_\_\_ Policy Holder Social Security Number \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_ Telephone: ( )

Policy Number: \_\_\_\_\_ Certificate Number: \_\_\_\_\_

Group Number: \_\_\_\_\_ Policyholder: \_\_\_\_\_ Relationship to Policyholder: \_\_\_\_\_

Policy Holder Date of Birth: \_\_\_\_\_ Policy Holder Social Security Number \_\_\_\_\_

### Responsible Party

Name: Mr./Mrs./Ms. \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_  
Street City State Zip

Home Phone: ( ) Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: ( )

Address: \_\_\_\_\_  
Street City State Zip

### Responsible Party/Guarantor's Signature

\_\_\_\_\_

**Authorization:** I have read and agree to the terms and conditions on the reverse side of this form and I hereby authorize the release of any medical information necessary to process my health insurance claim and request payment of benefits to the provider of services. This also includes authorization for Medicare. I understand I am financially responsible to Consultants in Gastroenterology, P.C./The Endoscopy Center, Inc. for charges not covered or denied by my insurance company. **I further agree in the event of my non-payment, to pay the cost of collection and/or court costs and reasonable fees should this be required.**

**Insured/Patient's Signature** \_\_\_\_\_