**Gastrointestinal Specialists P.C.**

Name: _____ SSN: _____
LAST FIRST MIDDLE INT

Birth date: _____ Age: _____ Sex: M F Marital Status: S M W D

**Race:** American Indian, Asian, African American, Caucasian, Declined, Other_____ **Preferred Language**_____
**Ethnicity:** Hispanic or Latino, not Hispanic or Latino, Unknown, Declined

Address: _____
STREET CITY ST ZIP CODE

Home Phone #: ( ) _____ E-Mail Address: _____

Work Phone #: ( ) _____ Cell Phone #: ( ) _____

Employer: _____ Employer address: _____

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If you were referred by a Physician please list their name and address below.

_____
REFERRING DOCTOR ADDRESS

Please list Primary Care Physician below: (If different from above)

_____
PRIMARY DOCTOR ADDRESS

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**PRIMARY INSURANCE:**

_____

Subscriber Name_____ Employer Name: _____

Date of Birth_____ Employer Address_____
CITY ST ZIP CODE

Relation to insured: Self Spouse Child

Insured's ID Number_____ Group #_____

**SECONDARY INSURANCE:** _____

Subscriber Name_____ Employer Name_____

Date of Birth_____ Employer Address_____
CITY ST ZIP CODE

Relation to Insured Self Spouse Child

Insured's ID Number_____ Group #_____

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**OFFICE POLICY REGARDING INSURANCE:** Your insurance is a method of reimbursement to you for professional expenses paid to the physician and is not a substitute for payment. Some companies pay fixed amounts for certain procedures and others pay a percentage of the charge. You will be responsible for any deductibles, co-payments, or other balances not paid by your insurance, including no call/no show fees without 24 hour notification to cancel/change appointment.

**IT IS EXPECTED THAT CHARGES FOR OFFICE VISITS WILL BE PAID AT THE CONCLUSION OF EACH OFFICE VISIT.**

**AUTHORIZATION FOR DIRECT BILLING:** I hereby assign all medical and/or surgical benefits, including major medical benefits (Medicare, private insurance, and other health insurances) to Gastrointestinal Specialists PC. This assignment will remain in effect until revoked by me in writing. A photocopy is considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize assignee to release information in my medical record to third party payers to secure payment for services rendered.

SIGNED_____ DATE_____

RESPONSIBLE PARTY_____ DATE_____