

NEW PATIENT REGISTRATION

GASTROENTEROLOGY SPECIALISTS, INC.

NAME _____ BIRTHDATE _____ AGE _____
last first mi

ADDRESS _____
p.o. street city state zip

HOME PHONE (____) _____ CELL PHONE _____ EMAIL ADDRESS _____ MARITAL STATUS _____

SOC. SEC. # _____ DRIVERS LIC# AND STATE _____

EMPLOYER _____ WORK PHONE (____) _____

SPOUSES NAME _____

SPOUSES EMPLOYER _____ WORK PHONE (____) _____

NAME OF DOCTOR, RELATIVE, FRIEND, (OR SELF) WHO REFERRED YOU _____

CLOSEST RELATIVE NOT LIVING WITH YOU(RELATIONSHIP) _____

last first phone

street city state zip

PREFERRED PHARMACY NAME _____ LOCATION _____

PRIMARY INSURANCE CARRIER _____ ID # _____

POLICYHOLDER _____ D.O.B. _____ RELATIONSHIP _____

SECONDARY INSURANCE CARRIER _____ ID # _____

POLICYHOLDER _____ D.O.B. _____ RELATIONSHIP _____

PLEASE KEEP YOUR INSURANCE CARDS OUT ---- ---- WE WILL WANT TO COPY THEM.

INSURANCE AUTHORIZATION, ASSIGNMENT AND RECORDS RELEASE

I hereby authorize Gastroenterology Specialists, Inc. to furnish information to insurance carriers concerning my health and treatment. I assign to the physician all payments for medical services rendered to me or my dependents. I understand that I am responsible for any amount not covered by insurance. I authorize Gastroenterology Specialists, Inc. to obtain my medical records including but not limited to medication lists from my pharmacy to ensure quality of care.

DATE _____ SIGNATURE _____