**GASTROENTEROLOGY ASSOCIATES**
**PATIENT INFORMATION**

Patient Name: _____
(last) (first) (middle)
Address: _____
City: _____State: _____Zip: _____
Home Phone: _____Work Phone: _____
Alternate Phone/Cell: _____
Email Address: _____
Social Security #: _____Date of Birth: _____
Sex: M or F Race: _____ Marital Status: _____
Primary Care Physician: _____
Referring Doctor: _____
Pharmacy Name/Address: _____
Hospital Preference: _____
Employer Name: _____
Employer Address: _____
Emergency Number:_____ Contact Person:_____
Do You Have a Living Will or Advance Directive? _____YES _____NO
How Did You Hear About Us? _____

**INSURANCE POLICYHOLDER'S INFORMATION**
**(IF OTHER THAN PATIENT)**

PRIMARY INSURANCE POLICY:
Policyholder's Name: _____
(last) (first) (middle)
Relationship to Insured: _____
Policyholder's Insurance ID #: _____ Policyholder's Date of Birth: _____
Policyholder's Address: _____
City: _____ State: _____ Zip: _____
Name of Employer: _____

SECONDARY INSURANCE POLICY:
Policyholder's Name: _____
(last) (first) (middle)
Relationship to Insured: _____
Policyholder's Insurance ID #: _____ Policyholder's Date of Birth: _____
Policyholder's Address: _____
City: _____ State: _____ Zip: _____
Name of Employer: _____

I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical benefits directly to this practice for the services rendered. I also understand that I, the patient, am financially responsible to pay any balance on my account.

_____ _____
**Patient's Signature** **Date**