GASTROINTESTINAL MEDICINE ASSOCIATES, INC.
PATIENT INFORMATION SHEET

Patient Name____

FIRST MIDDLE LAST

Mailing Address____

Street Address____

City____________________**State**______________**Zip**__________

Home Phone #__________________**Cell Phone #**__________________

Work Phone #__________________**Date of Birth**__________________

Please Circle Preferred Contact Phone Number: (Home / Cell)

Social Security #__________________ **Marital Status** ______________

Employer____

E-mail____

Emergency Contact ____

Relationship to Patient____________________**Phone#**______________

Doctor/Person Referring You__________________________________

Primary Care Physician__________________________________

Pharmacy__________________________**Phone #**________________

City and State of Pharmacy__________________________________

PLEASE CIRCLE ONE:
Race:
American Indian or Alaska Native
Asian
Native Hawaiian or Other Pacific Islander
Black or African American
White
Hispanic
Other Pacific Islander
Unreported/Refused to Report
Other Race__________________

PLEASE CIRCLE ONE
Ethnicity:
Hispanic or Latin
Not Hispanic or Latin
Refused to Report

Primary Language:________________________

OVER

MEDICAL INSURANCE COVERAGE INFORMATION—PAGE 2

Primary Insurance Carrier____
Primary Insurance ID/Member #____
Primary Insurance Group #____
Subscriber Name______________________________ **Date of Birth**_____________

Secondary Insurance Carrier____
Secondary Insurance ID/Member #_______________________________________
Secondary Insurance Group #____
Subscriber Name______________________________ **Date of Birth**_____________

Tertiary Insurance Carrier____
Tertiary Insurance ID/Member #____
Tertiary Insurance Group # ____
Subscriber Name______________________________ **Date of Birth**_____________

PATIENTS WITH HEALTH INSURANCE

I hereby authorize Gastrointestinal Medicine Associates, Inc., to release information to my insurance carrier(s) regarding my medical services and treatment in order to file a claim. I hereby assign all payments for medical services rendered to myself and dependents. I understand that I am financially liable for any co-pays, cost share, deductible, or co-insurance rendered to myself or dependents. I am responsible to pay within 30 days of my first bill or I will be subject to a 1.5% interest charge per month. If it becomes necessary to file suit to collect this bill, I agree to pay court costs and reasonable attorney fees to the extent permitted by law. A copy of this signature is valid as the original.

SIGNATURE:____________________________________**DATE:**_____________

PATIENTS WITHOUT HEALTH INSURANCE

I understand that I am financially responsible for any and all services rendered to me by Gastrointestinal Medicine Associates, Inc. Payment is due at the time of service unless other arrangements have been made. I am responsible to pay within 30 days of my first bill or I will be subject to a 1.5% interest charge per month. If it becomes necessary to file suit to collect this bill, I agree to pay court costs and reasonable attorney fees to the extent permitted by law. A copy of this signature is valid as the original.

SIGNATURE:___________________________________**DATE:**________________