



**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 \_\_\_\_\_ )

**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: \_\_\_\_\_