GASTROINTESTINAL MEDICINE ASSOCIATES, INC.

www.GIMEDRI.com

PATIENT INFORMATION SHEET

Patient Name ____

FIRST MIDDLE LAST

Mailing Address____

Street Address____

City_______________**State**__________**Zip**__________**Marital Status** __________

Home Phone #___________**Cell Phone #** ___________ **Work Phone#** ___________

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

Date of Birth__________**Employer** _______________**Primary Language**:__________

E-mail____

Emergency Contact _______________**Relationship:**__________**Phone#**__________

Doctor/Person Referring You ____

Primary Care Physician ____

Pharmacy_____________**Phone #**__________**City and State of Pharmacy** __________

MEDICAL INSURANCE COVERAGE INFORMATION

Primary Insurance Carrier_______________**Insurance ID/Member#** _______________
Primary Insurance Group# _______________ **Subscriber Name/DOB**_______________

Secondary Insurance Carrier_______________**Insurance ID/Member#** _______________
Secondary Insurance Group# _______________**Subscriber Name/DOB**_______________

Tertiary Insurance Carrier_______________**Insurance ID/Member#** _______________
Tertiary Insurance Group#_______________**Subscriber Name/DOB**_______________

*****FOR MEDICARE PATIENTS ONLY*****

IN THE EVENT OUR OFFICE NEEDS TO GET PRIOR AUTHORIZATION FOR YOUR MEDICATIONS, DO YOU HAVE PRESCRIPTION DRUG COVERAGE?

Plan Name:______________________________ **ID #** ______________________

****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:**__________

******OVER******

****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:________________

PLEASE CIRCLE ONE: 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________________________

Ethnicity:
Hispanic or Latin
Not Hispanic or Latin
Refused to Report