Advanced Gasteroenterology ASSOCIATES

Patient Demographics

Date: ______________

Patient Information

First Name: ______________________ Last Name: _________________________ Date of Birth: ________________

Email: ____

Address:____________________________________ City: ___________________ State: _______ Zip: _________

Phone Home: __________________ Mobile: __________________ Work: __________________

Marital Status:

❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Civil Union

I would like to receive appointment reminders ❑ Yes ❑ No

Primary Care Physician: _____________________ Referring Physician: _____________________

Optional Questions

Preferred Language: _____________________ Race: ❑ American Indian/Native American ❑ Black/African American

❑ Asian ❑ Native Hawaiian/Pacific Islander ❑ Caucasian ❑ Hispanic/Latin ❑ Other _________________________

Responsible Party ❑ Self

First Name: ______________________ Last Name: _________________________ Date of Birth: ________________

Email: ____

Address:____________________________________ City: ___________________ State: _______ Zip: _________

Phone Home: __________________ Mobile: __________________ Work: __________________

Emergency Contact

First Name: ______________________ Last Name: _________________________ Relationship: ________________

Email: ____

Address:____________________________________ City: ___________________ State: _______ Zip: _________

Phone Home: __________________ Mobile: __________________ Work: __________________

Employer Information

Occupation: _____________________________ Employer: ____

Address:____________________________________ City: ___________________ State: _______ Zip: _________

Phone: __________________ Fax: __________________

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Insurance Information

Primary Insurance: ______________________________ Relationship to Subscriber: ___________________________________

ID Number: _____________________________________ Group Number: ____

Subscriber Name:_________________________________ Birthdate: ______________________ Subscriber SS Number: _____________________

Secondary Insurance: ____________________________ Relationship to Subscriber: ___________________________________

ID Number: _____________________________________ Group Number: ____

Subscriber Name:_________________________________ Birthdate: ______________________ Subscriber SS Number: _____________________

Pharmacy

Name:____ Phone: ____

Address:____ City: __________________________ State: ________ Zip: ___________

Additional Information

How did you hear about us?

❑ Friend/Family ❑ Our Website ❑ Physician Referral ❑ Google/Search Engine ❑ Social Media ❑ Magazine/Publication

❑ Online Review/Rating System ❑ Hospital Referral

❑ I assign all medical/surgical benefits to Advanced Gastroenterology Associates P.A. and understand that I am financially responsible for all charges whether or not they are paid by insurance. I authorize payment to be made to the provider. In the event that the payment is made to the policyholder, I agree to submit payment in full to this office immediately. If the account is not paid in full, and prior arrangements have not been made, your account(s) may be referred to a collection agency. If your account is referred to an agency, you will be responsible for all attorney's and/or collection fees.

❑ I hereby authorize the providers to release or procure all information necessary to secure the payments of benefits, for treatment purposes, or to another health care provider or destination at my discretion. I may revoke this authorization at any time in writing, with the exception of insurance disclosures for billing purposes. I consent to communicate via electronic mans for routine matters. I further agree that a photocopy of this agreement she be as valid as the original. I certify the above information is true and correct to the best of my knowledge. I understand that HIPPA and privacy policies are available upon request.

❑ I have read and understand the information on this form.

____ ______________________________

Signature Date