



Date: _____ **PATIENT REGISTRATION** New Patient Update Info.

Please PRINT and complete ALL sections below!

Is your condition a result of a work injury? Yes NO An auto accident? YES NO Date of injury: _____

Patient Name: _____ Middle: _____ Last name: _____

M__ F__ Date of Birth: __/__/____ Social Security # ____ - ____ - ____ Driver's License (state) _____

Marital Status: Single Married Common Law Divorced/Separated Widow

Residence: Private Home Nursing Home Residential Treatment Center Skilled Nursing Facility Other

This is my Address as of (date) _____ Head of household: Yes No

Address: _____ City: _____ State: ____ Zip: _____

Mailing address: _____ City: _____ State: ____ Zip: _____

Home Phone : () _____ Work: () _____ Cell () _____

E-mail: _____

May our staff leave messages on your home answering machine? Yes No

May our staff leave messages with a family member? Yes No Who? _____

May our staff call or leave messages with your listed work number? Yes No

May our office staff utilize your e-mail address for correspondence or as means to reach you? Yes No

Emergency Contact: Name of person not living with you: _____

Relationship: _____ Address: _____ City: _____

State: ____ Zip: ____ Home phone: () _____ Work: () _____

REFERRAL INFORMATION

Referring Physician's

Name: _____ Address: _____

City: _____ State: ____ Zip: ____ Phone: () _____



Primary Care Physician's

Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone () _____

Employment Status

employed Y N student Full-time part-time contract retired date:(_____)

Employer Name: _____ Your Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____ Phone:() _____

Patient/Responsible Party Information

Responsible Party: _____ Date of Birth: _____

Relationship to Patient: self spouse other _____ Social Security ____ - ____ - ____

Responsible Party's Home Phone:() _____ Work:() _____

Address: _____ City: _____ State: _____ Zip: _____

Employer's Name: _____ Phone:() _____

Address: _____ City: _____ State: _____ Zip: _____

You're Occupation: _____

Primary Insurance: Please bring your insurance cards with you on the day of your appointment.

Insurance Plan Name: _____ Name of Insured: _____

Insurance ID: _____ Policy Group/FECA: _____

Secondary Insurance

Insurance Plan Name: _____ Name of Insured: _____

Insured ID : _____ Policy Group / FECA: _____

Check if appropriate: Medigap Policy Retiree Coverage



Preferred Pharmacy: (important) _____

Address: _____ City: _____ State: _____ Zip: _____

Phone:() _____ Fax:() _____

ASSIGNMENT OF BENEFITS

FINANCIAL AGREEMENT

Date: _____ To: (Insurance Co.) _____

Group No. _____ Cert. No. _____

I hereby give authorization for payment of insurance benefits to be paid directly to Advanced Gastroenterology, Inc. and any assisting physicians, for services rendered. I understand that I am financially responsible for all changes not covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this health care provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

❖ **Release of information**

I also authorize Advanced Gastroenterology, Inc. to release to my Insurance company or its representative, any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Medical or Surgical care.

Patient Signature: **X** _____ Print Name: _____

Signature of insured: **X** _____ Print Name: _____

❖ **Notice of Privacy Practices**

I _____, have received a copy of Advanced Gastroenterology, Inc.'s Notice of Privacy Practices. Patient Signature: **X** _____

Fees:

Initial _____ Patient must notify Advanced Gastroenterology Inc., of any cancellations or changes to scheduled procedures at least 3 days in advanced to avoid the \$75.00 fee.

Initial _____ Patient must notify Advanced Gastroenterology Inc., of any cancellations or changes to scheduled office appointments at least 48 hours prior to your appointment to avoid \$25.00 fee.

Initial _____ Payments made by check: a fee of \$25.00 will be added per transaction to any non-sufficient funds (any returned checks) .