(805) 719-0244 | Fax: (805) 777-1730
2220 Lynn Road, Suite 303 | Thousand Oaks, CA 91360
www.AGImedical.com

Date: ________________

PATIENT REGISTRATION

☐ New Patient ☐ Update Info.

Please PRINT and complete ALL sections below, and fax forms to (805)777-1730, THANK YOU.

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

Address: ___________________________________ City: ___________________________State:_____ Zip: _____________

Mailing address: _________________________________City:________________________State:______ Zip: ______________

Home Phone :( )___________________ Work: ( ) _________________ Cell: ( ) __________________

E-mail:____ (to obtain reports of your results)

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

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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 :( )____________________

Taking care of you inside and out.

Primary Care Physician

Name: ______________________________________ Address: ___________________________________

City: ____________________________ State: _____ Zip: ______________ Phone: ( ) ______________________

Employment Status

Employed: Yes ☐ No ☐ student: Full-time ☐ part-time ☐ contract ☐ retired ☐ date :(___________)

Employer Name: ____ 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 and your picture I.D. 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: _______________________________

We use E-script which sends your prescriptions via the internet to your local pharmacy if they participate.

Preferred Pharmacy: ____

Address: ____________________________________ City: ______________ State: ______ Zip: _____________

Phone :( ) _________________________ Fax :( ) _____________________________

Taking care of you inside and out.

Extended Signature Authorization
(Financial agreement, release of medical information, Notice of Privacy Practices)

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 understand that if my account is outstanding more than sixty days it may be sent to a collection agency. I hereby authorize this health care provider to release all information necessary to secure the payment of benefits.

I 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.

I authorize any holder of medical information about me to release this information to Advanced Gastroenterology, Inc., as necessary for the management of my healthcare. I further agree that a photocopy of this agreement shall be as valid as the original.

_______I further authorize Advanced Gastroenterology, Inc. to release any information to: ________________________ Relationship to Patient: ☐ spouse ☐ other :___________________________________, including my ☐ financial account, ☐ the diagnosis and the records of any ☐ treatment or ☐ examination rendered to me during the period of such Medical or Surgical care (please initial and check off the records that can be released).

Fees:

- **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.**
- **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.**
- **Payments made by check: a fee of $30.00 will be added per transaction to any non-sufficient funds (Any returned checks)**

Test results :

Labs, imaging, pathology or procedure results will be discussed at your follow up appointment. The doctor may call you with any critical or abnormal result, otherwise no results will be discussed over the phone.

Patient Signature: X______________________________________ Date: __________________________

Print Name: ____

Signature of insured: X____ (If other than patient) Date: ___________________

Print Name: _____________________________________