(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

Race: _______________________ Ethnicity: __________________________ Language: __________________________

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: ( ) __________________

Your personal E-mail:_____________________________________ (access to patient portal at www.agimedical.com click on portal link, call our office to obtain temporary access code for log in)

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

---

REFERRAL INFORMATION

How did you find Dr. Gilbert Simoni? Referring Physician On-line phone book Other:_______________

Name: ____ Phone :( )____________________

Address:____ City: ___________________________ State:____ Zip:___________

Primary Care Physician

Name: ____ Phone :( )____________________

Address: City: State: Zip:

Patient/Responsible Party Information: Insurance Subscriber Name

Name (If other than Patient): ______________________________ Date of Birth: ______________

Relationship to Patient: ☐ spouse ☐ other ______________ Social Security: _____-_____-______

Phone: ( ) ___________ Work: ( ) ________________ Cell: ( ) ______________

Address: ________________________City: ______________State:____ Zip: ________

Employer's Name: ______________________Phone :( ) ______________

Address: ________________________ City: ______________ State: ____ Zip: ________

Occupation: ______________________________________

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

Name of Insured: ______________ DOB: ________ Insurance Plan Name: ______________

Insurance ID: ________________ Policy Group/FECA: ______________

Secondary Insurance
Insurance Plan Name: ______________________Name of Subscriber: ______________

Social Security: - - DOB: / / Insured ID: Policy Group / FECA:

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

Relationship: Home phone :( ) Work :( )

Patient Employment Status

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

Employer Name: ______________________ Occupation: ______________________

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

We use E-script to send your prescriptions electronically to your local or mail order pharmacy if they participate. With this feature we are able to obtain current pharmacy records/prescriptions to be current with your list of medications.

☐ Yes, I give AGI consent to obtain my pharmacy records ☐ No, I do not give AGI consent to obtain my pharmacy records

Local Pharmacy: ______________________________________

Phone: ( ) __________________ Fax: ( ) __________________

Address: ________________City:__________ State: _____ Zip: __________

Mail order Pharmacy: ______________________ Phone ( ) ______________

Address: ________________City:__________ State: _____ Zip: __________

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

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.

Patient initials here: _______ I further authorize Advanced Gastroenterology, Inc., to release any information to:
Print Name of person Authorized: ____ Relationship to Patient:
Spouse ☐ Other: ☐ __________________________ including my financial account, diagnosis, treatment or examination rendered to me during the period of such Medical or Surgical care.

Fees:

- Patient must notify Advanced Gastroenterology Inc., of any cancellations or changes to scheduled procedures at least 5 days in advance to avoid the $200.00 fee.
- Payments made by check: a fee of $30.00 will be charged per transaction to any non-sufficient funds checks sent in for payment (returned checks).
- On-line Patient Portal messages answered by Dr. Simoni will be charged $25.00 each.

Test Results:
Labs, imaging, pathology or procedure results will be discussed at your follow up appointment. The doctor (or staff) will call you with critical or abnormal results, otherwise no results will be discussed over the phone without prior review by physician, once reviewed patients get email notification to view on Patient portal (ask for your password to access your chart).

I______________________________ have received a copy of Advanced Gastroenterology, Inc.'s Notice of Privacy Practices.
(Print Name) (available to read on-line at www.agimedical.com)

Patient Signature: X____ Date: _____________________

Signature of Insurance Subscriber (if other than Patient): X___________________________________ Date: ______________

Print Name (if other than Patient): ____