GASTRO HEALTH

2355 Derr Rd., Suite A, Springfield, OH 45503 • Phone 937-629-0100 • Fax 937-629-3285 • GastroHealth.com/Springfield

Patient Information - Please Print

Patient Information

Name *(First, Middle, Last)* ____________________ Date of Birth ____________ ❑ Male ❑ Female

Street Address ________________________________ Apt. No. __________

City ______________ State ________ Zip Code __________ Social Security No. ____________

Phone *(Check which you prefer)* ❑ Home ____________ ❑ Cell ____________ ❑ Daytime ____________

Email Address ______________________ Marital Status ❑ Single ❑ Married ❑ Other

Race *(Please select one)* ❑ White ❑ Black/African Am. ❑ Asian ❑ Hispanic/Latino ❑ Hawaiian/Pacific Islander ❑ Other ______

Preferred Language *(Please select one)* ❑ English ❑ Other __________

Ethnicity *(Please select one)* ❑ Hispanic/Latino ❑ Non-Hispanic/Latino ❑ Unknown

Primary Care Physician ____________________ Cardiologist ____________________

Pharmacy ____________________ Location ____________________

Employer Name ________________________________

Emergency Contact Name ____________________ Relationship ____________________

Emergency Contact Home Phone ____________________ Cell Phone ____________________

HIPPA

Privacy Information: Besides you, with whom may we discuss your medical information? Name ____________________

Relationship ____________________ Phone ____________________

Insurance Information

Insurance Name ________________________________

Policy ID No. ____________________ Group No. ____________________

Primary Insurance Policy Holder Name ____________________ Social Security No. ____________________

Date of Birth ______________ ❑ Male ❑ Female Relationship to Patient ______________

If you have Medicare:
Are you or your spouse employed? ❑ Yes ❑ No If yes, do you or your spouse have insurance through your employer? ❑ Yes ❑ No

Insurance Name ________________________________

Policy ID No. ____________________ Group No. ____________________

Primary Insurance Policy Holder Name ____________________ Social Security No. ____________________

Date of Birth ______________ ❑ Male ❑ Female Relationship to Patient ______________

I hereby authorize Gastro Health - Springfield and/or Gastro Care to use and/or disclose my health information to carry out my treatment, obtain payment and conduct healthcare operations. I understand this consent is voluntary. I have been informed that Gastro Health - Springfield and/or Gastro Care have a Notice of Privacy Practices, which fully describes how they will use and disclose my health information and that a copy of this is posted in the waiting room and that there are copies available for my review. I understand that the Physicians of Gastro Health - Springfield and/or Gastro Care have a financial interest in Gastro Health - Springfield and/or Gastro Care, and that I have the option to choose another healthcare facility for my procedures. I hereby authorize payment of medical benefits that are billed to my insurance to Gastro Health - Springfield and/or Gastro Care. I accept responsibility for payment for services provided to me that are not covered by my insurances. By providing this information on this form, I am authorizing Gastro Health - Springfield and/or Gastro Care to contact me and/or speak with the persons I have provided on this form.

Type your full name and date below as your digital signature.

Save and email your completed forms to Springfield@GastroHealth.com

____

Signature *(Patient or Guardian)* Date