GASTRO HEALTH

Gastro Health

PATIENT REGISTRATION

(Please Print)

PATIENT INFORMATION

Name: _____
First Middle Last

Address: _____

Apartment #: _____

City,State, ZIP: _____

Phone: _____ [ ]Home [ ]Work [ ]Cell [ ]Other

Phone: _____ [ ]Home [ ]Work [ ]Cell [ ]Other

Email Address: _____

Preferred Method of Contact:
[ ]Home Phone [ ]Cell Phone [ ]EMail via Portal

Sex: [ ]M [ ]F

Patient ID #: _____

Date of Birth: _____ Age: _____

Marital Status: [ ]Married [ ]Single [ ]Other

Referring Physician: _____

Primary Physician: _____

[ ] Power of Attorney Relation: _____

Name: _____

I acknowledge that by signing as POA/DPOA that I will present a notarized copy for your records to be valid.

PATIENT EMPLOYMENT

[ ]Employed [ ]Retired [ ]Unemployed

Employer: _____

Phone: _____

Occupation: _____

EMERGENCY CONTACTS

Name	Relation	Phone

PERSON RESPONSIBLE FOR PAYMENT

[ ]Same as Patient

Name: _____

Address: _____

Apartment #: _____

City,State: _____

Paperless Statement? **[ ] Yes [ ] No**

Email: _____

Employer: _____

Phone: _____

Date of Birth: _____

PRIMARY INSURANCE

[ ]Same as Patient [ ]Same as Guarantor [ ]Other

Subscriber Name: _____

Subscriber Phone: _____

Insurance Company: _____

Sex: [ ]M [ ]F **Employer:** _____

Patient Relationship to Insured: _____

Insured ID: _____

Group #: _____

Date of Birth: _____

SECONDARY INSURANCE

[ ]Same as Patient [ ]Same as Guarantor [ ]Other

Subscriber Name: _____

Subscriber Phone: _____

Insurance Company: _____

Sex: [ ]M [ ]F **Employer:** _____

Patient Relationship to Insured: _____

Insured ID: _____

Group #: _____

Date of Birth: _____

Your doctor agrees to accept Medicare payments in full except for the deductible, co -insurance and non-covered services. These charges will be your responsibility to pay. All co-insurance payments are due at the time of service. I understand I am responsible for obtaining a referral from my primary care physician if one is required.

I accept financial responsibility for all account balances over 30 days. Any accounts that are referred for collection will be charged reasonable collection fees and attorney fees.

I authorize the doctor to release information to my referring doctor and/or my insurance company. I authorize all insurance benefits to be paid directly to the doctor.

_____ Signature

_____ Date