

Gastro Health

(formerly Puget Sound Gastroenterology)

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

PATIENT REGISTRATION

(Please Print)

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