G.I SPECIALISTS, INC. PATIENT REGISTRATION DATE _____

PATIENT INFORMATION

SOCIAL SECURITY #_____ HOME ADDRESS_____

FIRST NAME_____MIDDLE_____ CITY_____STATE_____ZIP_____

LAST NAME_____ E-MAIL ADDRESS: _____

SEX _____ DATE OF BIRTH _____/_____/_____ HOME PHONE (_____)_____

MARITAL STATUS ☐ MARRIED ☐ SINGLE WORK PHONE (_____)_____

☐ DIVORCED ☐ WIDOWED CELL PHONE (_____)_____

(CHECK ONE) ☐ EMPLOYED ☐ RETIRED ☐ FULL TIME STUDENT REFERRING PHYSICIAN _____

EMPLOYER _____ HOW DID YOU HEAR OF US?_____

INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

☐ Commercial ☐ Medicare ☐ Medicare Advantage ☐ Medicaid ☐ Other _____

INSURANCE COMPANY _____PAYOR ID_____

CLAIMS ADDRESS _____

SUBSCRIBER'S NAME _____SUBSCRIBER DATE OF BIRTH _____

POLICY #_____GROUP #_____PHONE (_____)_____

SECONDARY INSURANCE INFORMATION

☐ Commercial ☐ Medicare ☐ Medicare Advantage ☐ Medicaid ☐ Other _____

INSURANCE COMPANY _____PAYOR ID_____

CLAIMS ADDRESS _____

SUBSCRIBER'S NAME _____SUBSCRIBER DATE OF BIRTH _____

POLICY #_____GROUP #_____PHONE (_____)_____

SPOUSE / GUARANTOR/ RESPONSIBLE PARTY

SOCIAL SECURITY #_____ HOME ADDRESS_____

FIRST NAME_____MIDDLE_____ _____

LAST NAME_____ CITY_____STATE_____ZIP_____

SEX _____ DATE OF BIRTH _____/_____/_____ HOME PHONE (_____)_____

RELATONSHIP _____EMPLOYER_____EMPLOYER PHONE (_____)_____

EMERGENCY CONTACT

FIRST NAME_____MIDDLE_____ HOME PHONE (_____)_____

LAST NAME_____ WORK PHONE (_____)_____

RELATIONSHIP_____ SEX _____

AUTORIZATION TO PAY BENEFITS TO PHYSICIAN: I request that authorized benefits be made to G.I. Specialists, Inc. for any services funished to me by that provider realizing I am responsible to pay ded, co-ins, copay & non-covered services.

_____
SIGNATURE (Patient or Parent if Minor) DATE

AUTHORIZATION TO RELEAE INFORMATION: I hereby authorize G.I. Specialists to release any information acquired in the course of my treatment necessary to process insurance claims.

_____
SIGNATURE DATE

AUTHORIZATION FOR MEDICARE: I request that payment of authorized Medicare benefits be made either to me or on my behalf to G.I. Specialists, Inc. for any services furnished to me by that provider of service. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits.

_____
SIGNATURE

_____
DATE

Revised 04/