

Patient Information Record

(Please Print)

Physician: _____

Patient Information

Patient Name: _____ Marital Status: _____ Date of Birth: ____ / ____ / ____ Sex: _____

Full Address: _____
(Street) (City) (State) (ZIP)

Home Phone: _____ Social Security No. _____ Driver's License No. _____

Employer: _____ Address: _____
(Street) (City) (State) (ZIP)

Work Phone: _____ Cell Phone: _____ Referring Physician: _____

Spouse Name: _____ Spouse's Employer: _____

Spouse's Employer Address: _____ Phone: _____
(Street) (City) (State) (ZIP)

Emergency Contact: _____ Phone: _____

Preferred Pharmacy: _____ Address: _____
(Street) (City) (State) (ZIP)

Responsible Party Information (if other than patient)

Person Responsible for Payment: _____ Relationship: _____ Phone: _____

Full Address: _____ Home Phone: _____
(Street) (City) (State) (ZIP)

Insurance Information

Primary: _____ Claims Address: _____
(Street) (City) (State) (ZIP)

Insured/Member: _____ Relationship: _____ Date of Birth: ____ / ____ / ____ Sex: _____

Employer: _____ Group No.: _____ Policy/Member No.: _____

Secondary 1: _____ Claims Address: _____
(Street) (City) (State) (ZIP)

Insured/Member: _____ Relationship: _____ Date of Birth: ____ / ____ / ____ Sex: _____

Employer: _____ Group No.: _____ Policy/Member No.: _____

Secondary 2: _____ Claims Address: _____
(Street) (City) (State) (ZIP)

Insured/Member: _____ Relationship: _____ Date of Birth: ____ / ____ / ____ Sex: _____

Employer: _____ Group No.: _____ Policy/Member No.: _____

Billing Notice and Release of Information

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid by your healthplan. For Medicare patients, this represents any unmet deductible and 20% of the allowed amount.

I authorize the release of any information to my healthplan and payment directly to my physician for services rendered. For Medicare patients, I request that payment of authorized Medicare benefits be made on my behalf to Metropolitan Gastroenterology Assoc. for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

Date

Patient Signature