**HARFORD GASTROENTEROLOGY ASSOCIATES, P.A.**
Physicians Pavilion II
510 Upper Chesapeake Drive, Suite 416
Bel Air, Maryland 21014
443-643-4700

**HARFORD ENDOSCOPY CENTER**
2214 Old Emmorton Road, Suite 100
Bel Air, Maryland 21015
410-838-6345
www.harfordendoscopy.com
Fax: 410-838-1595

**HARFORD GASTROENTEROLOGY ASSOCIATES, P.A.**
251 Lewis Lane, Suite 105
Havre de Grace, Maryland 21078
410-939-5082

# PATIENT INFORMATION SHEET

NAME ______________________________ (LAST / FIRST / MI)

SS # ______-______-______

ADDRESS ______________________________ APT __________

DATE OF BIRTH ____-____-____

CITY ______________________ STATE ________ ZIP CODE __________

MARITAL STATUS: ☐ S ☐ M ☐ D ☐ W

HOME PHONE ______________________ WORK PHONE ______________________

CELL PHONE ______________________ EMAIL ______________________

SEX: ☐ Male ☐ Female

DRUG ALLERGIES: ______________________

EMPLOYER ______________________________
(If retired-give name of company)

ADDRESS ______________________________

REFERRING PHYSICIAN ______________________________

ADDRESS / PHONE ______________________________

## WHOM TO NOTIFY IN CASE OF EMERGENCY

NAME ______________________________ RELATIONSHIP ______________________

ADDRESS ______________________________ HOME PHONE ______________________

CITY ______________________ STATE ________ ZIP CODE __________ WORK PHONE ______________________

Please Check off the following. This information is requested by the Department of Health and Mental Hygiene, for Statistical reporting purposes only. Your response is appreciated.

**ETHNICITY**

☐ 1. African American ☐ 2. American Indian/Eskimo ☐ 3. Asian ☐ 4. Hispanic ☐ Pacific Islanders ☐ 6. Caucasian ☐ 7. Other

## PRIMARY INSURANCE

COMPANY ______________________ ***POLICY HOLDER'S***

ADDRESS ______________________ NAME ______________________ SS # ______-______-______

______________________ DATE OF BIRTH ______________________ POLICY# ______________________

PHONE ______________________ EMPLOYER ______________________ GROUP # ______________________

## SECONDARY INSURANCE

COMPANY ______________________ ***POLICY HOLDER'S***

ADDRESS ______________________ NAME ______________________ SS # ______-______-______

______________________ DATE OF BIRTH ______________________ POLICY# ______________________

PHONE ______________________ EMPLOYER ______________________ GROUP # ______________________

## INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize release of any medical information necessary to process any insurance claims and I authorize payment of medical benefits directly to HARFORD GASTROENTEROLOGY ASSOCIATES, P.A. / HARFORD ENDOSCOPY CENTER for myself or my dependents. I understand that I am responsible for any Deductibles, Co-insurances, Co-pays, or other amounts not covered by my insurance companies. If a referral is required and is not presented at the time of service, service will be denied until the referral is obtained.

DATE ______________________ SIGNATURE ______________________________

## CONFIRMATION OF PATIENT INFORMATION ON DAY OF PROCEDURE/APT.

I have reviewed my patient demographic and insurance information on this date and verify that all information reported to the Center is correct.

DATE ______________________ SIGNATURE ______________________________