

ALLIED GASTROINTESTINAL ASSOCIATES, P.A.

Patient Registration

PATIENT INFORMATION

Date _____

Last Name _____ First _____ Middle Initial _____

Address _____ City, State, Zip _____

Home Phone # _____ Work Phone # _____

Name & Phone # of Emergency Contact Person _____

Social Security # _____ Birth Date _____ Age _____

Gender Male Female Marital Status S M W D Smoker ? Yes No

Name of Spouse or Guardian _____

Were you referred here by a physician? Yes No If yes, please give his/her name & address

Do you have a family physician? Yes No If yes, please give his/her name & address

DO YOU HAVE ANY KNOWN ALLERGIES TO MEDICATIONS? Yes No

If yes, please list _____

INSURANCE INFORMATION

Primary Carrier _____

Address _____

Identification/Policy # _____ Group # _____

Name & birth date of plan subscriber _____

Social Security # of subscriber _____

Does your primary insurance carrier require you to have a referral for medical services? Yes No

Does your primary insurance carrier require pre-certification for medical services? Yes No

Secondary Carrier _____

Address _____

Identification/Policy # _____ Group # _____

Name & birth date of plan subscriber _____

Social Security # of subscriber _____

Does your secondary insurance carrier require you to have a referral for medical services? Yes No

Does your secondary insurance carrier require pre-certification for medical services? Yes No

EMPLOYMENT INFORMATION

Name & address of your employer _____

Your occupation _____

ALL PATIENTS – PLEASE READ & SIGN

I hereby authorize ALLIED GASTROINTESTINAL ASSOCIATES, P.A. to keep this record of my signature on file for verification of treatment and as authorization to obtain any and all of my medical information which I may request be released. I also authorize ALLIED GASTROINTESTINAL ASSOCIATES, P.A. to keep this signature on file for any insurance benefits to be assigned to them.

Signature _____ Date _____

Medicare Patients – Please Read & Sign

I request that payment of authorized Medicare benefits be made on my behalf to ALLIED GASTROINTESTINAL ASSOCIATES, P.A. for any services furnished to me by ALLIED GASTROINTESTINAL ASSOCIATES, P.A. I authorize any holder of medical information about me to release to the Health Care Financing Administration or its agents any information needed to determine these benefits or the benefits payable for related services.

Signature _____ Date _____