Consultants In Gastroenterology, PA

Please complete this form in full prior to leaving the office. Thank You.

Name: _____ Date: _____
(FIRST, MIDDLE, LAST)

Address: _____
(STREET, P.O. BOX)

_____
(CITY, STATE, ZIP, COUNTY)

Home Telephone: _____ Business Telephone: _____

Social Security #: _____ Driver's License #: _____

Age: _____ Date of Birth: _____ Sex: _____

Allergies: _____

Employer: _____ Address: _____

Martial Status: _____ Insured's Name: _____

Insured's Social Security #: _____ Insured's Business Phone #: _____

Insured's Employer: _____

Insured's Date of Birth: _____ Relationship: _____

Person to Contact in Case of Emergency: _____ Phone #: _____

Relationship: _____

Name of Referring Physician: _____

Insurance Information: It is the Patient's Responsibility to Notify the Insurance Company prior to Admission if Precertification is necessary.

Primary Insurance Company: _____ Policy #: _____

Address and Phone # to Send Claim: _____

Secondary Insurance Company: _____ Policy #: _____

Address and Phone # to Send Claim: _____

Name of Policy Holder and Relationship: _____

I certify that all of the above information is correct.

_____
(PATIENT'S SIGNATURE OR RESPONSIBLE PARTY)

Please let the receptionist make a copy of your insurance card. Thank you.