CENTER for DIGESTIVE MEDICINE

PATIENT INFORMATION

Name:			Sex: Female ☐ Male ☐
Date of Birth: / /		Social Security No:	
Address:			Apt No. / Suite:
City:		State:	Zip Code:
Telephone ( )		Cellular ( )	
Email Address:			
Language:		Race:	Ethnicity:
Marital Status:	Single ☐ Married ☐	Divorced ☐	Widowed ☐ Seperated ☐
Employer:			Telephone ( )
Referring Physician:			Telephone ( )
Reason for Visit:			
Emergency Contact:			Telephone ( )

INSURANCE INFORMATION

Primary Insurance:			Telephone ( )
Subscriber:		Subscriber Date of Birth:	/ /
Policy No.	Group No.		Effective:
Secondary Insurance:			Telephone ( )
Subscriber:		Subscriber Date of Birth:	/ /
Policy No.	Group No.		Effective:

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:

I hereby authorize payment directly to Center for Digestive Medicine of benefits due to me from my Insurance Company otherwise payable to me. I further authorize the release of any medicalinformation required by my insurance carrier(s) and to any Healthcare Provider involved in my treatment upon written or oral request of such provider. A copy of this authorization may be used in lieu of the original. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers of any information needed for this or a related Medicare claim.

I understand that I am fully responsible for the payment of all charges that are not covered and paid for by the insurance. I further understand that I shall be wholly responsible for all collection charges. This includes Court cost reasonable attorney fees incurred in any attempts to collect delinquent unpaid charges and all charges shall accrue intrest at the rate of eighteen percent (18%) per annum from the initial billing date.

Patient's Signature:_____ **Date:**_____