PATIENT INFORMATION FORM

Patient Information:

Last Name _____ First Name _____ MI _____

Mailing Address _____ (include apt #)

City _____ State_____ Zip _____

Social Security # _____ Date of birth _____ Age_____

Gender: M F **(circle one)** Married, Single, Widowed, Divorced **(circle one)**

Home Phone _____ Cell Phone _____

Do we have your permission to leave a message if we are unable to reach you?_____ Please initial_____
Do we have permission to send test results to your family physician? _____ Please initial_____

Family Physician _____ Referring Physician _____

Pharmacy_____ Pharmacy Phone Number _____

Primary Insurance Information:

Name of Insurance _____ Date of Birth _____

Policy Holder Name _____

Insurance ID # _____ Group # _____ Relationship _____

Secondary Insurance Information:

Name of Insurance_____ Date of Birth _____

Policy Holder Name_____

Insurance ID # _____ Group # _____ Relationship _____

This section to be completed if you are under 18

Name of Parent or Legal Guardian _____

Address_____

Relationship to Patient _____

I authorize Summit Gastroenterology Associates, Inc. to submit any information needed to my insurance company. I understand that any balance due after the claim has processed is my responsibility. Failure to pay the balance due could delay future appointments. This document also serves as my consent for treatment.

By signing below, I certify that I have read and understand the above statement. All information I have entered on this form is accurate, and true.

_____ _____

Patient Signature (you *must be 18 or over to sign*) **Date**

Parent or Legal Guardian must sign if patient is under 18