ADVANCED DIGESTIVE CARE
ASSOCIATES IN GASTROENTEROLOGY

Associates in Gastroenterology, P.C.: Patient Registration

Last Name:	First Name & M.I.:	Date of Birth:	Sex: M F
Address:			
City/State/Zip:			
Home Phone:	Cell Phone:	Work Phone:	
Social Security Number:		Email: Do we have permission to email you? Y N	
Primary Care Physician name:			
Referring Physician name:			
Preferred Pharmacy name:		Pharmacy address:	
Patient Employer:		Employer Address:	
City/State/Zip:			
Insurance Carrier:	Insurance ID #:	Insurance Group #:	
Insurance Subscriber's Name (Last, First, M.I.):			
Relationship to Patient:	Date of Birth:	Insurance Subscriber's Social Security Number:	
Insurance Subscriber's Employer:			
Insurance Carrier Address:			
City/State/Zip:		Insurance Carrier Phone:	
Secondary Insurance Carrier:	Insurance ID #:	Insurance Group #:	
Emergency Contact's Name:		Relationship to Patient:	
Home Phone:	Cell Phone:	Work Phone:	

Authorization to Pay Benefits to Physician: I hereby authorize payment directly to Associates in Gastroenterology, P.C., otherwise payable to me for services rendered, realizing I am responsible to pay non-covered services. I also realize that I am responsible for any other cost incurred while collecting my outstanding balance(s).

Authorization to Release Information: I hereby authorize Associates in Gastroenterology, P.C., to release any information acquired in the course of my treatment necessary to process insurance claims.

No Show Policy: I understand that Associates in Gastroenterology, P.C. may charge a $30 fee to me if I fail to present for a scheduled appointment. If I need to reschedule or cancel, I will coordinate with the office staff at least 24 hours prior to the scheduled appointment.

Signature Date

Waiver: I, _____, agree to be seen by Associates in Gastroenterology, P.C., on this date. I acknowledge that I did not bring a referral as required by my insurance company and/or I do not have my insurance card. I am electing to be seen today and agree to pay for services rendered without a valid referral or insurance card.

Signature Date