GASTROENTEROLOGY ASSOCIATES OF THE PIEDMONT, P.A.

PATIENT INFORMATION

LAST NAME	**FIRST NAME**	**MIDDLE NAME**	**MAIDEN NAME**
ADDRESS		**BIRTHDATE**	**AGE**
CITY	**STATE** **ZIP**	**SEX** ☐Male ☐Female	**SS#**
HOME PHONE	**CELL PHONE** **WORK PHONE**	**MARITAL STATUS** *(circle one)* M S SEP D W	
NAME OF SPOUSE		**SPOUSE DOB**	
YOUR EMPLOYER		**SPOUSE EMPLOYER**	**SPOUSE WORK PHONE**
REFERRING PHYSICIAN (Full Name)		**PRIMARY CARE PHYSICIAN (Full Name)**	
EMERGENCY CONTACT	**RELATIONSHIP**	**PHONE**	
PHARMACY NAME	**ADDRESS**	**PHONE**	
EMAIL		**May we contact you at this email?:** **YES** **NO**	

How did you hear about us? ☐ **Doctor** ☐ **Friend** ☐ **Internet** ☐ **Advertisement** ☐ **Community Event** ☐ **Health Fair** ☐ **Other**_____

PERSON RESPONSIBLE FOR PAYMENT *(if other than patient)*

NAME	**RELATIONSHIP**
ADDRESS	**HOME PHONE**
EMPLOYER	**WORK PHONE**

INSURANCE INFORMATION *(Please present insurance card(s) to the receptionist on arrival)*

PRIMARY INSURANCE	**Subscriber ID#**	**Group#/Plan**
Employer Name	**Name of Employee**	**Employee's Date of Birth**
SECONDARY INSURANCE (IF APPLICABLE)	**Subscriber ID#**	**Group#/Plan**
Employer Name	**Name of Employee**	**Employee's Date of Birth**

CONSENT FOR PATIENT COMMUNICATION *(Appointment reminders, scheduling, test results)*

May We Call You At Home? ☐ **YES** ☐ **NO**	**May We Call You At Work?** ☐ **YES** ☐ **NO**
May We Leave A Detailed Message? ☐ **YES** ☐ **NO**	**If "NO," explain:** _____

You have my permission to disclose my Patient Health & Billing Information to the following person(s):

1.	**3.**
2.	**4.**

The notice of privacy practices has been made available to me or will be available at the time of my initial appointment.

By signing below, I request that payment of authorized Medicare benefits or other third party insurance benefits be made to GASTROENTEROLOGY ASSOCIATES OF THE PIEDMONT, P.A. for any services furnished me by that group. I authorize any holder of medical information about me to release any information needed to determine these benefits for related services. I hereby authorize Medicare to furnish to the above named practice any information regarding my Medicare claims under Title XVIII of the Social Security Act.

_____ _____

Patient Signature ***Today's Date***