

MAIN LINE GASTROENTEROLOGY ASSOCIATES, P.C.

Patient Information Record

Please PRINT all information

Date \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

E-mail Address \_\_\_\_\_ Social Security# \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Circle one: Sex M F Marital Status: S M W D Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse's Work Phone \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Emergency Contact (other than spouse) \_\_\_\_\_ Relationship \_\_\_\_\_

Emergency Contact Phone \_\_\_\_\_

Family Doctor \_\_\_\_\_ Phone \_\_\_\_\_

List other doctors seen regularly \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_ Phone \_\_\_\_\_

Who recommended that you consult a gastroenterologist?

( ) Family Doctor (above)

( ) Another Physician \_\_\_\_\_ Phone \_\_\_\_\_

( ) Other \_\_\_\_\_

INSURANCE INFORMATION

Insurance company and address \_\_\_\_\_

Name of Policyholder \_\_\_\_\_ Group# \_\_\_\_\_

Policy/ID# \_\_\_\_\_ Medicare# \_\_\_\_\_

Policyholder employer \_\_\_\_\_ Policyholder Date of Birth \_\_\_\_\_

CONSENT/ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION

I understand and agree that Main Line Gastroenterology Associates may provide treatment to me and may use and disclose protected health information about me for treatment, payment and/or health care operations. I authorize payment of medical benefits on my behalf to Main Line Gastroenterology Associates for services received. I also authorize the release of any medical or other information necessary to process my claims.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

DO NOT MAIL THIS FORM

Reviewed for accuracy: \_\_\_\_\_