

**PATIENT REGISTRATION**

**GASTROENTEROLOGY AND HEPATOLOGY SPECIALISTS, INC.**

**Patient Information:**

**DO NOT MAIL THIS FORM!**

**BRING PAPERS WITH YOU!**

Patient Name: \_\_\_\_\_ Birth date: Mo/Day/Yr \_\_\_\_\_  
 Address: \_\_\_\_\_ Sex: (check) Marital Status: (check)  
 City/Zip: \_\_\_\_\_  Male  Single  Married  
 Social Security # \_\_\_\_\_  Female  Divorced  Widowed  
 Home Phone #: ( ) \_\_\_\_\_ Employer: \_\_\_\_\_  
 Work Phone #: ( ) \_\_\_\_\_ Address: \_\_\_\_\_  
 Cell Phone #: ( ) \_\_\_\_\_ City/Zip: \_\_\_\_\_  
 If retired, from where?: \_\_\_\_\_

**Responsible Party Information (who to balance bill, if other than patient):**

Name: \_\_\_\_\_ Relationship to Patient  Spouse  Child  Other  
 Address: \_\_\_\_\_ Social Security # : \_\_\_\_\_  
 City/Zip: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Home Phone #: ( ) \_\_\_\_\_ Address: \_\_\_\_\_  
 Work Phone #: ( ) \_\_\_\_\_ City/Zip: \_\_\_\_\_  
 Cell Phone #: ( ) \_\_\_\_\_

**Emergency Contact Person and Phone #:**

Relative: \_\_\_\_\_ Non-Relative: \_\_\_\_\_  
 Phone #: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Relationship: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Referring Physician and/or Primary Care Physician Information:**

Name of Referring Physician: \_\_\_\_\_  
 Address: \_\_\_\_\_ City/Zip: \_\_\_\_\_ Phone#: ( ) \_\_\_\_\_  
 Name of Primary Care Physician (if different from Referring M.D.) \_\_\_\_\_  
 Address: \_\_\_\_\_ City/Zip: \_\_\_\_\_ Phone#: ( ) \_\_\_\_\_

DO YOU REQUIRE A WRITTEN REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN TO BE SEEN IN OUR OFFICE?  Yes  No

**It is your responsibility to make sure that referrals are in place before your scheduled appointment with our practice.**

**PLEASE COMPLETE BACK OF THIS PAGE ALSO**

**Insurance Coverage:** Please give us all pertinent insurance information regarding coverage. If you have coverage by more than one carrier, supply the information on both carriers. We will file a maximum of 2 insurance claims per service date. Please show all numbers and addresses on your card(s). Please make sure and complete the effective date of the policy. IF YOUR COVERAGE IS CONTINGENT ON A REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN OR PRECERTIFICATION IS REQUIRED THEN IT IS YOUR RESPONSIBILITY TO INFORM US.

Primary Carrier Name: _____	Secondary Carrier Name: _____
Claims Address: _____	Claims Address: _____
City/Zip: _____	City/Zip: _____
Name of Insured: _____	Name of Insured: _____
Relationship to Patient: _____	Relationship to Patient: _____
Insured's ID #: _____	Insured's ID #: _____
Group # or Company Name: _____	Group # or Company Name: _____
Effective Date: _____	Effective Date: _____

Note: In order to submit a claim for payment to our practice for services covered under your policy, we must have authorization to release medical information to your insurance carrier.

MEDICARE PATIENTS: I request that payment of authorized Medicare benefits be made to GHS for any services furnished me by those physicians. I authorized any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits made payable for related services. I hereby authorize Medicare to furnish the above named doctors any information regarding any Medicare claims under Title XVIII of the Social Security Act.

COMMERCIAL INSURANCE PATIENTS: I hereby authorize release of information necessary to file a claim with my insurance company and **ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE DOCTOR OR GROUP INDICATED ON THE CLAIM.** This assignment is only revocable in writing by me. I understand and acknowledge that the medical record may contain information regarding psychiatric disorders, Human Immune Virus (HIV) test results, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related conditions, alcohol and/or drug dependence/abuse. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE CARRIER. I have read all the information on this form and my answers are true and correct to the best of my knowledge.

A copy of this signature is valid as the original.

\_\_\_\_\_  
Patient's Signature

**Note: Signature is required in order to submit your insurance claims. If you refuse to sign, then we will require payment at time of service. Thank you for your cooperation.**