# GASTROENTEROLOGY CONSULTANTS, P.C.

Patient Name (LAST):_____ (FIRST)_____ (MI)_____

Address:_____ City:_____ Zip:_____

Telephone Number:_____Date of Birth:_____

Work contact phone number: _____ Cell phone: _____

E-mail address _____ Circle one: MALE FEMALE

Marital Status: ___Married ___Single ___Widowed ___Divorced ___Partnered

**Optional:** ___ White ___African American ___Asian ___Hispanic ___ Other_____

Language: ___English ___Spanish ___French ___Other _____ ___Refuse to report

Patient Employer:_____ Telephone:_____

Emergency Contact:_____Telephone:_____

**Primary Insurance Co.** (*Please list both name and address*):_____

_____

Policy Holder Name:_____ ID#:_____ Grp#:_____

**Secondary Insurance Co.** *(Please list both name and address)*:_____

_____

Policy Holder Name:_____ ID#:_____ Grp#:_____

**Referring Physician:**_____Telephone ( )_____

**Primary Care Physician**:_____Telephone ( )_____

## INSURANCE AUTHORIZATION/ASSIGNMENT:

I hereby authorize **Gastroenterology Consultants, P.C.** to release necessary information to insurance carriers acquired in the course of my treatment.

Signature:_____ Date:_____

I hereby assign payment of medical benefits for me or my dependent(s) to **Gastroenterology Consultants, P.C.**

Signature:_____ Date:_____