GASTROENTEROLOGY CONSULTANTS, P.C.

M. Thomas Riddick, M.D.

11660 Alpharetta Hwy., Ste 420
Roswell, GA 30076
(770) 442-5882 Fax (770) 754-9749

Patient Name _____Date of Birth_____Male/Female

Social Security Number_____Email : _____

Address_____Apt. No. _____

City_____State_____Zip_____ Marital Status: _____ Race_____

Home ( )_____Cell ( ) _____ Work ( ) _____

Employer_____Address_____

Employment Status: Full-time Part-time Unemployed Retired Self-Employed Military
(Circle One)

Spouse's Name_____
Spouse's Employer_____Phone_____

Insurance Information: Insured Name_____
(if different than patient) Insured Date of Birth_____
Insured SS#_____
Person to contact in case of Emergency_____Phone_____
Who is your Primary Care Physician?_____Phone_____
Name of Physician Referring you to our practice_____

Insurance Information: I acknowledge that M. Thomas Riddick, M.D. may or may not be a part of my provider network for my insurance company and that it is my responsibility to verify that Dr. Riddick is on my plan. All professional services rendered are charged to the patient. We will file your insurance as a courtesy, however, the patient is responsible for all fees regardless of insurance coverage.

I hereby authorize Dr. Riddick to furnish all information to insurance carriers concerning my illness and treatments and I hereby assign to the physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance.

Date_____Signature_____