GASTROINTESTINAL MEDICINE ASSOCIATES, INC.

www.GIMEDRI.com

PATIENT INFORMATION SHEET

Patient Name _____

FIRST MIDDLE LAST

Mailing Address_____

Street Address_____

City_____**State**_____**Zip**_____**Marital Status** _____

Home Phone #_____**Cell Phone #** _____ **Work Phone#** _____

Please Circle Preferred Contact Phone Number: (Home / Cell / Work **)**

Date of Birth_____**Employer** _____**Primary Language**:_____

E-mail_____

Emergency Contact _____**Relationship:**_____**Phone#**_____

Doctor/Person Referring You _____

Primary Care Physician _____

Pharmacy_____**Phone #**_____**City and State of Pharmacy** _____

MEDICAL INSURANCE COVERAGE INFORMATION

Primary Insurance Carrier_____**Insurance ID/Member#** _____
Primary Insurance Group# _____ **Subscriber Name/DOB**_____

Secondary Insurance Carrier_____**Insurance ID/Member#** _____
Secondary Insurance Group# _____**Subscriber Name/DOB**_____

Tertiary Insurance Carrier_____**Insurance ID/Member#** _____
Tertiary Insurance Group#_____**Subscriber Name/DOB**_____

*****FOR MEDICARE PATIENTS ONLY*****
IN THE EVENT OUR OFFICE NEEDS TO GET PRIOR AUTHORIZATION FOR YOUR MEDICATIONS, DO YOU HAVE PRESCRIPTION DRUG COVERAGE?
Plan Name:_____ **ID #** _____

****PATIENTS WITH HEALTH INSURANCE****

I hereby authorize Gastrointestinal Medicine Associates, Inc., to release information to my insurance carrier(s) regarding my medical services and treatment in order to file a claim. I hereby assign all payments for medical services rendered to myself and dependents. I understand that I am financially liable for any co-pays, cost share, deductible, or co-insurance rendered to myself or dependents. I am responsible to pay within 30 days of my first bill or I will be subject to a 1.5% interest charge per month. If it becomes necessary to file suit to collect this bill, I agree to pay court costs and reasonable attorney fees to the extent permitted by law. A copy of this signature is valid as the original.

SIGNATURE:_____**DATE:**_____

******OVER******

****PATIENTS WITHOUT HEALTH INSURANCE****

I understand that I am financially responsible for any and all services rendered to me by Gastrointestinal Medicine Associates, Inc. Payment is due at the time of service unless other arrangements have been made. I am responsible to pay within 30 days of my first bill or I will be subject to a 1.5% interest charge per month. If it becomes necessary to file suit to collect this bill, I agree to pay court costs and reasonable attorney fees to the extent permitted by law. A copy of this signature is valid as the original.

SIGNATURE:_____DATE:_____

PLEASE CIRCLE ONE: PLEASE CIRCLE ONE

Race:
American Indian or Alaska Native
Asian
Native Hawaiian or Other Pacific Islander
Black or African American
White
Hispanic
Other Pacific Islander
Unreported/Refused to Report
Other Race_____

Ethnicity:
Hispanic or Latin
Not Hispanic or Latin
Refused to Report