Patient Information Record

(Please Print)

Physician: ________________________

Patient Information

Name: _______________________________________ **Marital Status**: ____ **Date of Birth:** ____ / ____ /____ **Gender:** ______

Full Address: ____
(Street) (City) (State) (ZIP)

Home Phone: ______________________ **Work Phone:** ________________________ **Cell Phone:** _________________________

Ethnicity: ❒ Hispanic ❒ Non-Hispanic **Preferred Language:** ❒ English ❒ Spanish ❒ Vietnamese ❒ Other________________

Race: ❒ American Indian ❒ Asian ❒ Black ❒ Pacific Islander ❒ White ❒ Other__________________________________

Driver's License No. _________________ **Social Security No:** _________________ **Referring Physician:** ____________________

Employer: _________________________________ **Address:** ____
(Street) (City) (State) (ZIP)

Preferred Pharmacy: _______________________________ **Address**: ____
(Street) (City) (State) (ZIP)

Spouse Name: ___________________________________ **Spouse's Employer**: ____

Spouse's Employer Address: ____ **Phone**: _______________
(Street) (City) (State) (ZIP)

Emergency Contact: ____ **Phone**: _______________

Responsible Party Information *(if other than patient)*

Person Responsible for Payment: ___________________________________ **Relationship**:________________________________

Address: ____ **Phone**: ___________________
(Street) (City) (State) (ZIP)

Insurance Information

PRIMARY: _____________________________ **Claims Address**: ____
(Street) (City) (State) (ZIP)

Insured/Member: _____________________ **Relationship**: __________________ **Date of Birth**: ___/ ___/ ___ **Gender**: ______

Employer: _______________________ **Group No.**: ______________________ **Policy/Member No.**:________________________

SECONDARY: _____________________________ **Claims Address**: ____
(Street) (City) (State) (ZIP)

Insured/Member: _____________________ **Relationship**: __________________ **Date of Birth**: ___/ ___/ ___ **Gender**: ______

Employer: _______________________ **Group No.**: ______________________ **Policy/Member No.**: ________________________

Billing Notice and Release of Information

Please remember that insurance is not a substitute for payment. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid by your healthplan. For Medicare patients, this represents any unmet deductible and 20% of the allowed amount.

I authorized the release of any information to my healthplan and payment directly to my physician for services rendered. For Medicare patients, I request that payment of authorized Medicare benefits be made on my behalf to Metropolitan Gastroenterology Assoc. for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

________________________ ____
Date Patient Signature