FLINT GASTROENTEROLOGY ASSOCIATES, PC PATIENT INFORMATION

Last Name	First Name	M	DOB

Address:

Social Security #_____

Email:_____@_____

Home#_____

Cell#_____

Race

White	Asian	Black	Hisp-Lat	Other
Pacific Isle	Refused	Unknown	Native American	

Ethnicity

Declined	Hispanic	Non-Hispanic	Unreported

Status

Married	**Divorced**	**Single**	**Widowed**

Gender: M / F

Current Employer:_____ **Phone Number:**_____

Primary Care Doctor:_____

Office#_____
Fax#_____

Referred by:_____
if other than your Primary

Pharmacy_____

Pharmacy #_____
Pharmacy location:_____

***We E-Prescribe prescriptions**

***Person to contact in case of emergency:** _____ **Phone:**_____
***Please list the family members or persons, if any, whom we may inform about your general medical condition and diagnosis. (You may list spouse, children, relatives etc.).** _ _____
_____
***Please provide a preferred telephone number where you want to receive calls.** _____
***Can we leave a confidential message about your care on your answering machine/voicemail?** _____

INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
GROUP#	GROUP #
CONTRACT#	CONTRACT #
NAME ON CARD	NAME ON CARD
BIRTHDATE	BIRTHDATE
SS#	SS#

Patient's relationship to subscriber: ❑ Self ❑ Child ❑ Spouse ❑ Other

PRIVACY STATEMENT: We protect our patient's information and the records that we have about their health and the services received in our office. We must have your written, signed consent in order to disclose your health information for the purposes of your treatment, the payment of your bills, appointment reminders etc. I have received a copy of the Privacy Notice. (HIPAA – 164.520) Effective 04/14/2003. If we refer our patients to another provider or Specialist, we may need to share your medical information with them. Your privacy is protected as only minimum information is shared.
X Patient/Guardian Signature:_____ Date_____

FINANCIAL RESPONSIBILITY: I authorize the release of medical information to insurance carriers concerning my illness and treatment and I hereby assign to the doctor all payments for medical services rendered to me or my dependent. I understand that I am responsible for any amount not covered by insurance and that I will pay any co-pays on the date of service unless other arrangements are made.
X Responsible Party Signature_____ Date_____

MEDICATION AUTHORIZATION: I request that payment of authorized Medicare benefits be made to Flint Gastroenterology Associates, PC on my behalf. I authorize the holder of my medical information to release to the HCFA and their agents any information needed to determine these benefits for related services. I understand that HCFA is the government Medicare agency.

_____ _____ _____
X Medicare Beneficiary Signature Date Medicare #