



PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ Apt#: _____ City: _____ State: _____ Zip: _____

Home#: _____ Work#: _____ Cell#: _____

Age: _____ Sex: M F Date of Birth: _____ Marital Status: _____ SS#: _____

Employer's Name: _____ Occupation: _____

Address: _____ City: _____ Zip: _____

EMAIL ADDRESS: _____

EMERGENCY CONTACT: _____ PHONE #: _____

SPOUSE INFORMATION

Name: _____ Home#: _____ Work#: _____ Cell#: _____

Address (if different than above): _____ Apt#: _____ City: _____ Zip: _____

Age: _____ Sex: M F Date of Birth: _____ SS#: _____

Employer's Name: _____ Occupation: _____

Address: _____ City: _____ State/Zip: _____

INSURANCE INFORMATION OF POLICY HOLDER

PRIMARY Insurance: _____ Address: _____ State/Zip: _____ Phone#: _____

ID #: _____ Group#: _____ Policy Holder Employer: _____

Name of Policy Holder: _____ Date of Birth: _____ SS#: _____ Relationship to Patient: _____

SECONDARY Insurance: _____ Address: _____ State/Zip: _____ Phone#: _____

ID #: _____ Group#: _____ Policy Holder Employer: _____

Name of Policy Holder: _____ Date of Birth: _____ SS#: _____ Relationship to Patient: _____

PRIMARY CARE DOCTOR: _____ Phone#: _____

Who referred you? _____ Phone#: _____

Assignment and Authorization of Benefits

I hereby give authorization for payment of insurance benefits to be made directly to Austin Gastroenterology, PA for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In event of default, I agree to pay all costs of collection and reasonable attorney fees. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this Agreement is as valid as the original.

Authorization for Email & Voicemail Usage for PHI

I hereby give permission to leave a message on my voicemail concerning my personal health information (decline option)

I hereby give permission to communicate, via email address listed above, my personal health information (decline option)

I further understand that this permission to communicate my personal health information will remain in effect until I request, in writing, to have this option of communication terminated.

Patient Signature

Date

Witness Signature

Date
10/06