Austin Gastroenterology
www.austingastro.com

Patient Demographic Information

Patient Name: _____

Age: _____ Date of Birth: _____ Gender: Social Security Number: _____

Address: _____ Unit / Suite / Apt#: _____

City, State Zip: _____ Email Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer's Name: _____

Employer's Address: _____ City, State Zip: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Are you currently residing in a skilled nursing facility? ◯ Yes ◯ No If yes, please provide the contact information of the nursing facility.

Name of Facility: _____

Facility Address: _____ City/State: _____ Zip: _____

Insurance Information

Primary: _____ Policy: _____ Group: _____

Address: _____ City/State/Zip: _____ Phone: _____

Policy Holder: _____ Date of Birth: _____ Relationship: _____

Policy Holder Employer Name: _____ Policy Holder SSN: _____ Policy Holder Gender: _____

Secondary: _____ Policy: _____ Group: _____

Address: _____ City/State/Zip: _____ Phone: _____

Policy Holder: _____ Date of Birth: _____ Relationship: _____

Policy Holder Employer Name: _____ Policy Holder SSN: _____ Policy Holder Gender: _____

Primary Care and Referring Physician Information

Are your Primary Care Physician and the referring Physician the same? ◯ Yes ◯ No

Primary Physician Name: _____ Primary Physician Phone: _____

Referring Physician Name: _____ Referring Physician Phone: _____

Authorization for Voicemail regarding Health Information

I hereby give permission to leave message(s) on my voicemail concerning my personal health information. **Initials:** _____

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.

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 the event of default, I agree to pay all costs of collection and responsible 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.

Austin Gastroenterology, P.A. frequently utilizes mid-level practitioners including: Physician Assistants and Advanced Practice Nurses to assist in the delivery of medical care. Mid-level practitioners are under the supervision of a physician and can diagnose, treat and monitor common acute and chronic diseases. I hereby consent to the services of a mid-level practitioner for my health care needs. I understand that at any time I can refuse to see the mid-level practitioner and request to see a Physician.

_____ _____

Signature of Patient or Legal Representative *Date*