ATLANTIC COAST GASTROENTEROLOGY ASSOCIATES, LLC.

PATIENT REGISTRATION FORM

PLEASE PRINT:

LAST NAME: _____ _____FIRST NAME: _____ MI _____ ___

ADDRESS : _____ ___

CITY : _____ STATE: _____ ZIP: _____

SEX: M / F DATE OF BIRTH: _____ MARRIED/SINGLE/WIDOWED/DIVORCED/OTHER

PREFERRED LANGUAGE: _____ ETHNICITY: _____ RACE: _____ __

PATIENTS SSN: _____ YOUR SPOUSES NAME: _____

HOME PHONE: _____ WORK # _____ CELL#

EMAIL ADDRESS :

EMPLOYEMENT STATUS: SELF / FT / PT / RETIRED / DISABLED / UNEMPLOYED / OTHER

PATIENTS EMPLOYER AND ADDRESS :

EMPLOYER PHONE : _____

PRIMARY CARE PHYSICIAN :

REFERRING DOCTOR :

INSURANCE INFORMATION:

INSURANCE :

INSURANCE ID#

GROUP # _____ RELATION TO SUBCRIBER: SELF / SPOUSE / CHILD / OTHER

SUBCRIBERS DATE OF BIRTH :

NAME OF SUBCRIBER: _____ SSN:

SUBCRIBERS EMPLOYER:

WORK ADDRESS AND PHONE : _____

_____

SECONDARY INSURANCE :

INSURANCE : _____

INSURANCE ID _____ GROUP # _____ ___

RELATION TO SUBCRIBER: SUBSCRIBERS DOB:

NAME OF SUBCRIBER: SSN:

SUBCRIBER EMPLOYER :

EMERGENCY CONTACT INFORMATION:

EMERGENCY CONTACT PERSON OTHER THAN SPOUSE :

EMERGENCY CONTACT # RELATION

EMERGENCY CONTACT WORK #

TO WHOM MAY WE GIVE OR OBTAIN INFORMATION TO: _____

ADVANCE DIRECTIVE? YES OR NO

PHARMACY INFORMATION:

NAME OF PHARMACY PHONE:

ADDRESS :

DRUG ALLERGIES:

LATEX ALLERGIES: DOCUMENTED / SENSITIVE :

LIST OF CURRENT MEDICATIONS:

INSURANCE AGREEMENT: I AUTHORIZE ATLANTIC COAST GASTROENTEROLOGY ASSOCIATES, LLC. TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY TREATMENT AND ILLNESS. I REQUEST THAT PAYMENT OF BENEFITS FROM MY INSURANCE CO. BE MADE TO ATLANTIC COAST GASTROENTEROLOGY ASSOCIATES, LLC. I REQUEST THAT PAYMENT OF MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO ATLANTIC COAST GASTROENTEROLOGY ASSOC. LLC FOR ANY SERVICE FURNISHED TO ME BY PHYSICIAN OR SUPPLIER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMIN AND IT AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICE. ALL PATHOLOGY/ BIOPSY SPECIMENS THAT ARE SENT TO OUTSIDE LABS ARE THE RESPONSIBILITY OF THE PATIENT FOR ANY PROCEDURE
THAT IS DONE THESE CHARGES ARE SEPERATE FROM THE PROCEDURE CHARGE.

PATIENT SIGNATURE: _____DATE:_____

***** please note our office will submit balances overdue more than 90days to an outside collection agency. *****