Eisenman & Eisenman M.D.
ADVANCED GASTRO CONSULTANTS

Patient Registration Form

PATIENT INFORMATION				
Patient's Last Name:	First Name:	Middle Name:		
Address:	City:	State:	Zip Code:	
Best phone number to reach you: ( )	*circle one* cell/work/home	Alternate phone number: ( )	Email Address:	
Date of Birth: / /	Age:	Sex: M F	Marital Status: Single Married Divorced Widowed Other	
Social Security #:	Employer Name and Address:			
If patient is a minor, please give parent/guardian names and specify relation to patient:				
What is your primary language? : English Spanish Creole Other: _____				
Primary Care Physician/Referring Physician: (Please Print Name) Phone: ( ) Do you need a Primary Care Physician?				

IN CASE OF EMERGENCY			
Name of Emergency Contact Person:	Relationship to Patient:	Cell Phone: ( )	Work Phone: ( )

INSURANCE INFORMATION		
Name of Primary Insurance:	Policy Subscriber's Name, if not Patient:	Policy Subscriber's Date of Birth: / /
Patient's relationship to subscriber:	Self Spouse Child Other, please specify:	
Name of Secondary Insurance (if applicable):	Policy Subscriber's Name, if not Patient:	Policy Subscriber's Date of Birth: / /
Patient's Relationship to Subscriber:	Self Spouse Child Other, please specify:	

Pharmacy Name:	Pharmacy Location:	Pharmacy Phone: ( )

I authorize the release of any of my medical information necessary for insurance/prescription certification or to process insurance claims. I also authorize the release of my medical records to any doctor, hospital, or ancillary care center participating in my care and treatment. Only medically necessary information will be released when requested. I understand that this information will either be faxed or mailed to the party requesting the information.

I hereby assign all medical benefits to include major medical benefits to which I am entitled to Eisenman & Eisenman M.D., Advanced Gastro Consultants. This assignment will remain in effect until revoked by me in writing. I further agree to be solely responsible for any balances that my insurance does not pay. I understand this to include, but not limited to any charges deemed above "reasonable and customary" by said insurance company. I further understand that I am responsible for any collection and/or legal fees incurred as a result of non-payment on my account.

Photocopies of these authorizations are to be considered legally valid as is the original.

PATIENT SIGNATURE: _____DATE: _____