BHARAT DASANI, MD (Director)
FIRST GI ENDOSCOPY AND SURGERY CENTER LLC

44 RT 23 North, Ste 7, Riverdale, NJ 07457 TEL: 973-248-1550 FAX: 973-248-1560

Patient Registration Form

Last Name :_____**First Name :**_____ **Middle :**_____ **Today's Date:** _____ **Sex:** _____

Address: _____ **Date of Birth:** _____ **Age:** _____

City _____**State:**_____ **Zip:** _____ **Race:** _____ **Language:** _____

E-Mail: _____ **Social Security Number:** _____

BELOW WRITE ONLY THOSE PHONE NUMBERS THAT WE CAN USE TO SHARE CONFIDENTIAL HEALTH INFORMATIONS

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

In Case of Emergency, who should be notified :_____ **Relationship to you :**_____

Phone Number :_____

Employer/ School Name and Address :_____

Primary Care Physician :_____ **Phone Number :**_____**Fax Number :**_____

Referring Physician : _____ **Phone Number :**_____**Fax Number :**_____

How did you hear about us? : ○*Website/Online* ○*Physician Referral* ○*Friend/Family Member* ○*Already a patient*

Pharmacy Name :_____ **Phone Number :**_____**Fax Number :**_____

Primary Insurance

Insurance Company Name: _____

Policy Holder: _____

Relationship to Policy Holder: _____

Date of Birth : _____

Policy Number: _____

Group Number: _____

Secondary Insurance

Insurance Company Name: _____

Policy Holder: _____

Relationship to Policy Holder: _____

Date of Birth : _____

Policy Number: _____

Group Number: _____

Assignment and Release

I certify that all information provided above is true to the best of my knowledge. I, the undersigned (patient or legal guardian) authorize medical and / or surgical treatment to be rendered by the doctor and his staff. I hereby authorize payment of insurance benefits to be paid directly to Bharat Dasani MD. I understand that I am financially responsible for all charges whether or not paid by insurance.

The above-named physican may use health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purposes of obtaining payment for services and determing insurance benefits payable for related services.

_____ _____

Signature of Patient,Guardian or Representative **Date**

HIPAA - Privacy Practice Acknowledgement

Notice of Privacy Practices states how we may use and/or disclose your health information. It is our policy not to release confidential medical information unless authorized in writing. I authorize to leave my medical information by the following method and will assume responsibility to notfiy whenever it changes.

I authorize to discuss my care with **No One**_____ **Spouse** _____ **Other** _____

I have received the notice of Privacy Practice and I have been provided an opportunity to review it.

_____ _____

Signature of Patient,Guardian or Representative **Date**