EDMUNDS GASTROENTEROLOGY

PATIENT INFORMATION

Patient's name_____ Age_____

Street Address_____

City_____ State_____ Zip Code_____

Home phone_____ Cell Phone_____ Work_____

Date of birth_____ Social Security #_____ Sex M F

Martial Status M D W Patient's Employer_____

Referring physician_____ Primary Care physician_____

Emergency contact_____ Emergency phone # _____

Pharmacy name, address phone #_____

Race_____ Language_____

Preferred method of contact __ Phone __ Mail __ email_____

Insurance Information (please bring card so that we may make a copy)

Primary Insurace_____

Policy # _____ Group #_____

Subscriber's Name _____Subscriber's DOB_____

Secondary Insurance_____

Policy # _____ Group # _____

Subscriber's Name _____ Subscriber's DOB _____

Signature of patient or authorized person _____

I hereby authorize the release of medical information necessary to report a claim to my I hereby assign benefits to me to the physician indicated on the claim. I understand that I am financially responsible for services not covered by my insurance plan,

***Medi*care patients**

I request that payment of authorized Medicare benefits be made to my physician. I authorize any holder of medical information needed to determine these benefits or the benefits payable for payable for related services. I also understand that I am responsible for payment for services not covered by the Medicare program.

Signature _____ Date_____