GASTROENTEROLOGY ASSOCIATES OF SUFFOLK

Specialists in Digestive Problems

DATE ___/___/___
NAME______________________________
ADDRESS______________________________
____
HOME PHONE ( )______________________
CELL PHONE ( )______________________
WORK PHONE ( )______________________ EXT. ______

PRIMARY CARE PHYSICIAN ______________________
Address______________________________
____
BIRTHDATE ___/___/___
MARITAL STATUS______________________
SS# ______ - ________ - ______

EMPLOYER____
ADDRESS____

WHOM TO CONTACT IN CASE OF EMERGENCY:
NAME______________________________________
RELATIONSHIP______________________________________
ADDRESS______________________________________
____
PHONE ( )__________________________ (other than home #)

PRIMARY INSURANCE INFORMATION:
CARRIER NAME / ADDRESS______________________________________
____
INSURED'S NAME & SS# ______________________________________
GROUP NAME & NUMBER ______________________________________
COPAY AMOUNT ____________________

SECONDARY INSURANCE INFORMATION:
CARRIER NAME / ADDRESS______________________________________
____
INSURED'S NAME & SS# ______________________________________
GROUP NAME & NUMBER ______________________________________
COPAY AMOUNT ____________________

HOW DID YOU HEAR OF OUR PRACTICE? (Check line)

___ PRIMARY CARE PHYSICIAN
___ ANOTHER PATIENT
___ WEBSITE
___ EMERGENCY ROOM / HOSPITAL
___ INSURANCE COMPANY
___ YELLOW PAGES
___ NEWSPAPER ADVERTISEMENT (Check One):
☐ Port Jefferson Times ☐ Smithtown Times ☐ North Shore Sun ☐ Other

PHARMACY: Name / Address______________________________________
Phone______________________________________

I am aware that I am personally responsible for all fees incurred for the medical services I receive, regardless of my possessing any medical insurance coverage or any existing agreement between the physicians and such insurance company regarding fees, methods of payment or handling of claims. Should the physicians decide to accept assignment of services rendered as full or partial payment, I hereby assign those benefits to be paid directly to them or their agent. I hereby authorize the release of medical information about me to my insurance carrier, the S.S. Administration, HCFA, or their intermediaries.

PATIENT / GUARANTOR SIGNATURE______________________________________