STAMFORD GASTROENTEROLOGY INC. PATIENT INFORMATION FORM

First Name: _____

Last Name: _____

Address: _____

City: _____ State: _____

Zip: _____

Home Phone: _____

Work Phone: _____

Mobile Phone: _____

Sex: **M** / **F**

Date of Birth (MM/DD/YYYY):_____

Patient email: _____

Emergency Contact Information

Name:

Relationship:

Phone:

Primary Insurance Information

Insurance Plan Name:

Policy Holder (if other than patient)	**Policy Information**
Last Name: _____	Patient's relationship to policy holder: _____
First Name: _____	ID/Certification No.: _____
Middle Name: _____	Policy/Group No.:
Address: _____	
City:_____ State:_____ Zip: _____	
Date of Birth: Sex (please circle): **M** or **F**	
Employer Name:	

Secondary Insurance Information

Insurance Plan Name:

Policy Holder (if other than patient)	**Policy Information**
Last Name:	Patient's relationship to policy holder:
First Name:	ID/Certification No.:
Middle Name:	Policy/Group No.:
Address:	
City: State: Zip:	
Date of Birth:**,** Sex (please circle): **M** or **F**	
Employer Name:	

ASSIGNMENT AND RELEASE:

- **I hereby assign my insurance benefits to be paid directly to the physician.**
- **I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan.**
- **I authorize the physician to release any medical information required to process this claim.**
- **I authorize my provider's office to contact me by telephone to remind me of my appointments.**
- **A fee for no shows may apply.**

Signed_____ **Date:**_____