Center for Gastrointestinal Medicine Patient Registration Form

For Office Use: Acct#_____ Date:_____

First Name_____ Init_____ Last Name_____

Address_____ City:_____ St_____ Zip_____

Home_____ Work_____ Cell_____ Sex: M F

Marital Status: M S D W Date of Birth_____ Age_____ SS#_____-_____-_____

Employer_____

Address_____ City:_____ St_____ Zip_____

How did you hear about our practice? _____

Primary Care Physician _____

Address_____ City:_____ St_____ Zip_____

Phone:_____ Fax:_____

Primary Insurance:_____ Secondary Insurance:_____

(Only the insurance company name (s), we will scan the cards in)

Are you the primary insured? Y N Are you the primary insured? Y N

If No: Name:_____ D.O.B: _____Relationship:_____

Emergency Contact: _____

Phone:_____ Relationship:_____

Authorization:

I authorize my medical information to be given to _____

Phone:_____ Relationship:_____

Patient Signature:_____

Have you been given a copy of the privacy policy to review? Y N

May we leave messages on your home answering machine as they pertain to lab results, appointments and benign pathology? Y N May we leave messages on your cell phone? Y N

Email Address:_____ Preferred Method of Contact: _____

It is required that the Center for Gastrointestinal Medicine of Fairfield and Westchester, PC keep a copy of your signature on file for billing purposes. This enables us to bill your insurance company for services rendered at the time of each visit electronically. Please sign below that you authorize the use of your signature for billing purposes.

Signature:_____ Print Name:_____ Date:_____