Alma|Gastroenterology

Patient Information Form

General Information: **Today's Date:**_____________

First Name:________________________ M Int._______ Last Name:______________________

Date of Birth:________________ Social Security Number___________________ Gender__________

Address:___________________________________ City:______________ State:___ Zip:_________

Home Phone:________________ Cell Phone:_________________ Work Phone: _______________

E-mail Address:_________________________________ Primary Language:_________________

Race: White African American Asian American Indian/Alaska Native Other Pacific Islander
(circle one)
Ethnicity: Hispanic or Latino or Not Hispanic or Latino
(circle one)

Occupation:______________________________ Employer:_______________________________

Address:___________________________________ City:______________ State:___ Zip:_________

Emergency Contact_____________________ Number__________________ Relationship__________

Primary Care Physician: ___________________________ Office Phone:_____________________

Address:____ Fax Number:____________________

Referring Physician :_____________________________ Office Phone:_______________________
(If different)

Address:____ Fax Number:_____________________

Pharmacy:____________________________________ Phone Number:______________________

Address:____________________________________ Fax Number:_________________________

Patient's Insurance

Primary Insurance: ____

Subscriber ID Number:________________________ Group Number:__________________________

Policy Holder Information: (If different from patient)

Name:____ Relationship:__________________

Date of Birth:________________ Social Security Number___________________ Gender_________

Employer:________________________________ Employer's Phone Number:__________________

Address:___________________________________ City:______________ State:___ Zip:________

Secondary Insurance: ____

Subscriber ID Number:________________________ Group Number:__________________________

Policy Holder Information: (If different from patient)

Name:____ Relationship:__________________

Date of Birth:________________ Social Security Number___________________ Gender_________

Employer:________________________________ Employer's Phone Number:__________________

Address:___________________________________ City:______________ State:___ Zip:________

Pharmacy:_____________________________________ Phone Number:______________________

Address:____

ASSIGNMENT OF BENEFITS (ALL NON-MEDICARE INSURANCE PLANS) To assist in the processing of my insurance claim, kindly furnish my insurance company with any information you may have regarding my condition while under your treatment. I authorize payment of benefits directly to Alma Gastroenterology, for service described. I accept full financial responsibility for services rendered. I authorize payment of medical benefits to the physician for services rendered

Signature:____ Date:_________________________

ASSIGNMENT OF BENEFITS (MEDICARE AND/OR MEDICAID) I authorize any holder of medical or other information about me to release to the Social Security Administration and The Health Care Financing Administration or their intermediaries or carriers, or the billing agent of this Physician, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself, or to the party who accepts this assignment.

Signature:____ Date:_________________________