Patient # ________________

REGISTRATION FORM

Staff Initials ________________

PLEASE PRINT Patient's Full Legal Name

____
Last First Middle

Social Security # _________ - _________ - __________

Mailing Address ____

____

City ________________________________ State _______ Zip ________________

Other names we may have treated you under ________________________________

E-mail Address: ____

Date of Birth: __________/_________/______________ Sex: (circle) Male / Female / Other

Family Doctor: ______________________________ Referred by: ______________________________

Patient's Primary Phone: (_____)____________________ Secondary Phone: (_____)________________

Work: (_____)________________

Employer Name: ____
Name Address Phone #

May we contact patient at work for appointment reminders/changes, test results, etc…? (circle) Yes / No

Is Patient Retired: (circle) Yes / No Date of Retirement: ______________________________

Race: (circle) White / African American / Asian / American Indian Other: ________________________

Are you Hispanic or Latino: Yes / No

What is your preferred language? ____________________________________

Marital Status: (circle) Single / Married / Divorced / Widowed

Spouse's Name: __________________________________ Spouse's Date of Birth: ____________________________

Emergency Contact Person: ____ ___________________________
Full Name Relationship

(________)________________________ (________)________________________ (________)________________________
Primary Phone Secondary Phone Work Phone

Preferred Pharmacy: ____ City: ________________________________

IS ANYONE OTHER THAN THE PATIENT RESPONSIBLE FOR THE ACCOUNT? (circle) Yes / No

* If patient is a minor, student or has a legal healthcare and/or financial power-of-attorney (If power-of-attorney, please provide legal documentation)

Guardian name: ____

Relationship to patient: ______________________________________ Date of Birth: ________/_________/___________

Address & phone if different from patient: ____

____

City: ____ State: ____________ Zip: ______________________

(________)________________________ (________)________________________ (________)________________________
Home Phone Work Phone Mobile Phone

I understand that Associated Gastroenterology Consultants, Inc. will file my insurance/supplemental health insurance claim form for me. I authorize payment of insurance benefits to be made to Associated Gastroenterology Consultants, Inc. for medical services rendered. I also understand that I am financially responsible for any copayment(s), deductible(s), coinsurance and/or balance from non-covered services that are owed to Associated Gastroenterology Consultants, Inc. for services rendered. This authorization will remain in effect until revoked by me in writing.

SIGNATURE ____ **DATE** ______________________

If not the patient please describe relationship: ____