The Gastroenterology Group

PATIENT INFORMATION SHEET FOR MEDICAL RECORDS (PLEASE PRINT)

SS#:_____-_____-_____

Patients Full Legal Name: _____E-mail: _____

Address: _____City:_____State:_____Zip:_____

Home Phone: ___-____-___ Cell:___-___-___ Date of Birth: ___-____-____ Sex: ☐ Male ☐ Female

Employed by: _____Work Phone:_____-_____-_____ Ext :_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow

Spouse's Full Legal Name: _____ ___Spouse's SS#: _____-_____-_____

Spouse's Date of Birth: ____-____-____ Spouse's Work Phone: ____-_____-____ Cell: ____-_____-_____

If Patient is a minor:

Who is responsible for the bill: _____Relationship:_____

Address of Responsible party: _____City:_____State:_____Zip:_____

Home Phone: ____-____-___ Cell: ____-____-____ Work Phone:____-_____-____ Ext :_____

NAME OF PATIENTS NEAREST RELATIVE OR FRIEND TO CONTACT IN EMERGENCY

Name: _____ Relationship:_____

Home Phone: ____-____-___ Cell: ____-____-____ Work Phone:____-_____-____ Ext :_____

INSURANCE INFORMATION:

DO YOU HAVE MEDICARE? ☐ YES ☐NO **MEDICARE** #:_____

First Insurance Company: _____

Address: _____ City:_____State:_____Zip:_____

Policy #:_____ Group#:_____

Insured's Name:_____ Insured's Date of Birth:____-____-____

Insured's Relationship to Patient :_____ Insured's SS#:____-_____-_____

Secondary Insurance Company: _____

Address: _____ City:_____State:_____Zip:_____

Policy #:_____ Group#:_____

Insured's Name:_____ Insured's Date of Birth:____-____-____

Insured's Relationship to Patient :_____ Insured's SS#:____-_____-_____

HOW DO YOU INTEND TO PAY? ☐CASH ☐CHECK ☐VISA ☐MASTER CARD ☐DISCOVER ☐AMERICAN EXPRESS

REFERRED BY: _____

REASON FOR TODAYS VISIT: _____

HOW LONG HAVE YOU BEEN HAVING THIS PROBLEM: _____

Date:_____ Signature:_____

Date:_____ Signature:_____