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Patient Information - Please Print

Reset Form

Patient Information

Name *(First, Middle, Last)* _____ Date of Birth _____ ☐ Male ☐ Female

Street Address _____ Apt. No. _____

City _____ State _____ Zip Code _____ Social Security No. _____

Phone *(Check which you prefer)* ☐ Home _____ ☐ Cell _____ ☐ Daytime _____

Email Address _____ Marital Status ☐ Single ☐ Married ☐ Other

Race *(Please select one)* ☐ White ☐ Black/African Am. ☐ Asian ☐ Hispanic/Latino ☐ Hawaiian/Pacific Islander ☐ Other _____

Preferred Language *(Please select one)* ☐ English ☐ Other _____

Ethnicity *(Please select one)* ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unknown

Primary Care Physician _____ Cardiologist _____

Pharmacy _____ Location _____

Employer Name _____

Emergency Contact Name _____ Relationship _____

Emergency Contact Home Phone _____ Cell Phone _____

HIPPA

Privacy Information: Besides you, with whom may we discuss your medical information? Name _____

Relationship _____ Phone _____

Insurance Information

Insurance Name _____

Policy ID No. _____ Group No. _____

Primary Insurance Policy Holder Name _____ Social Security No. _____

Date of Birth _____ ☐ Male ☐ Female Relationship to Patient _____

If you have Medicare:
Are you or your spouse employed? ☐ Yes ☐ No If yes, do you or your spouse have insurance through your employer? ☐ Yes ☐ No

Insurance Name _____

Policy ID No. _____ Group No. _____

Primary Insurance Policy Holder Name _____ Social Security No. _____

Date of Birth _____ ☐ Male ☐ Female Relationship to Patient _____

I hereby authorize Springfield Gastroenterology and/or Gastro Care to use and/or disclose my health information to carry out my treatment, obtain payment and conduct healthcare operations. I understand this consent is voluntary. I have been informed that Springfield Gastroenterology and/or Gastro Care have a Notice of Privacy Practices, which fully describes how they will use and disclose my health information and that a copy of this is posted in the waiting room and that there are copies available for my review. I understand that the Physicians of Springfield Gastroenterology and/or Gastro Care have a financial interest in Springfield Gastroenterology and/or Gastro Care, and that I have the option to choose another healthcare facility for my procedures. I hereby authorize payment of medical benefits that are billed to my insurance to Springfield Gastroenterology and/or Gastro Care. I accept responsibility for payment for services provided to me that are not covered by my insurances. By providing this information on this form, I am authorizing Springfield Gastroenterology and/or Gastro Care to contact me and/or speak with the persons I have provided on this form.

Type your full name and date below as your digital signature.

Save and email your completed form to gastro@springfieldgastro.com.

_____

Signature *(Patient or Guardian)* Date