Gastroenterology Specialists of Gwinnett, P.C.
PATIENT REGISTRATION

PATIENTS'S NAME: _____ SEX: M ___ F___ Other __ DATE OF BIRTH _____

RACE: _____ ETHNICITY: _____ LANGUAGE: _____SSN:_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ CELL: _____ WORK: _____

EMAIL: _____

PHARMACY NAME: _____LOCATION:_____ PHONE # _____

EMPLOYER: _____

SPOUSE'S NAME: _____ DATE OF BIRTH_____SSN:_____

HOME PHONE: _____CELL:_____

PRIMARY INSURANCE NAME: _____
ID # _____ GROUP # _____
POLICY HOLDER: _____ DOB: _____
RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE NAME: _____
ID # _____ GROUP # _____
POLICY HOLDER: _____ DOB: _____
RELATIONSHIP TO PATIENT: _____

PRIMARY CARE PHYSICIAN
NAME: _____
PHONE #: _____

REFERRING PHYSICIAN
NAME: _____
PHONE: _____

EMERGENCY CONTACT: (SOMEONE NOT LIVING WITH YOU)
NAME: _____ PHONE: _____ DOB: _____
RELATIONSHIP: _____

I authorize Gastroenterology Specialists of Gwinnett to release all information necessary to facilitate the processing of all claims related to my care. I authorize use of this signature on all my insurance submissions. I understand I am financially responsible for all charges for office visits and procedures: deductible, co-payment, and co-insurance, and any balance not paid by my insurance company. I understand that in the event that endoscopy procedures are performed, either rat Northeast Endoscopy Center or Gwinnett Medical Center, that a facility fee will be charges and that any deductibles, copays, co-insurance etc. which may apply are my responsibility. Any amount not paid by my insurance is due in full within 30 days of the insurance payment. I understand that I am responsible for all charges whether or not paid by insurance, including collections fees, attorney fees, court costs, etc. should account be turned over to collections. We assess a $30.00 fee for returned checks and a fee for collection action.

_____ _____
SIGNATURE OF PATIENT DATE