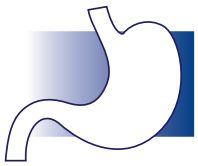

Associates *in*
Digestive Diseases
— Gastroenterology and Hepatology —

Patient Information (Please Print)

Name: _____Sex: ☐ Male ☐ Female

Date of Birth: _____Social Security Number: _____Marital Status: S M W D Civ U

Address: _____Apt/Unit: _____

City: _____State: _____Zip Code: _____

Home Phone: _____Cell Phone: _____Work Phone: _____Ext: _____

Email Address:_____

Would you like us to email you information about our Patient Portal? ☐ Yes ☐ Not interested

Preferred Contact Method: ☐ Home ☐ Cell ☐ Work ☐ I Want to be Texted Reminders for Appointments

Employer: _____Occupation_____

Primary Care Physician or Referring Physician: _____

Spouse's Name: _____Spouse's SS#: _____Date of Birth: _____

Spouse's Employer: _____Spouse's Occupation: _____

Insurance Information

*****Note: Correct insurance information is essential in order to avoid declined payments*****

Primary Insurance: _____Policy# _____Group #: _____

Address: _____Effective Date: _____Specialist Co-pay: _____

Policy Holder: _____Relationship to Policy Holder: _____

Secondary Insurance: _____Policy# _____Group #: _____

Address: _____Effective Date: _____Specialist Co-pay: _____

Policy Holder: _____Relationship to Policy Holder: _____

Insurance Release

I hereby authorize Associates in Digestive Diseases, PA to release information acquired in the course of medical examination or treatment to my insurance carrier and to file my health insurance claim forms for services rendered. I am responsible for the balance not paid by my insurance and any applicable deductible, co-insurance, and co-pay.

Patient Signature Date

Assignment of Benefits

I hereby authorize direct payment to Associates in Digestive Diseases, PA for services billed.

Patient Signature Date