

NEW PATIENT

PROCEDURE

UPDATE

GASTROENTEROLOGY CENTER, PA PATIENT INFORMATION FORM

- HANS ADAMS, MD
- WARREN HIATT, MD
- PETER BERNHEIM, MD
- SCOTT GIOE, MD

DATE: _____

Have you ever seen the doctors before? _____

Under what name? _____

PATIENT <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed (check one) <input type="checkbox"/> Male <input type="checkbox"/> Female	Last Name		First Name		Middle	Date of Birth
	Street Address		City	State	Zip	Age
	Mailing Address		City	State	Zip	Phone - Home
	Social Security Number					Phone - Pts. Work
	Name of Employer/School					Referred By
	Employer's Address					Spouse's Name
	Nearest Relative (not living with you)					Relationship
Address		City	State	Zip	Phone	
In Case of Emergency, Notify					Phone	

RESPONSIBLE PARTY <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other (check one)	Last Name		First Name		Middle	Social Security Number
	Billing Address					Date of Birth
	City, State, Zip					Phone - Home
	Employer					Phone - Work
	Employer's Address					

EVEN THOUGH INSURANCE COVERAGE IS LISTED, YOU ARE RESPONSIBLE FOR PAYMENT OF SERVICES.

METHOD OF PAYMENT

Cash Check Credit Card

INSURANCE INFORMATION	Primary Insurance		Secondary Insurance	
	Policy/Contract No.	Group No.	Policy/Contract No.	Group No.
	If Group, Name of Policy Holder (Employer, Union, Etc.)		If Group, Name of Policy Holder (Employer, Union, Etc.)	
	Insured's I.D. or Social Security No. (If other than self)		Insured's I.D. or Social Security No. (If other than self)	
	SEND CLAIMS TO:		SEND CLAIMS TO:	
RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS	Insurance Authorization and Assignment I hereby authorize my insurance company to pay benefits directly to Drs. Adams, Hiatt, Bernheim, and/or Gioe. I authorize the release of information to the insurance company for my claims to be paid with above insurance information provided. I acknowledge I am responsible for payment of services rendered.			
Signature of Insured/Responsible Party			Date	



NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I, _____, A PATIENT OF DR. _____
DO HEREBY ACKNOWLEDGE RECEIPT OF THE
GASTROENTEROLOGY CENTER PA NOTICE OF PRIVACY
PRACTICES IN ACCORDANCE WITH THE NEW HIPPA
REGULATIONS. I REALIZE THAT IF I HAVE ANY QUESTIONS
CONCERNING THESE PRIVACY PRACTICES, A MEMBER OF
THE STAFF OR THE PRIVACY OFFICER, RHONDA PARKER,
863-8836, EXT. 421, WILL EXPLAIN THEM TO ME.

PATIENT SIGNATURE

DATE