

Patient Information

Houston Gastroenterology Associates

PATIENT NAME (First Name, Middle Initial, Last Name)	PRIMARY PHONE ()	SECONDARY PHONE ()	EMERGENCY CONTACT NAME:
ADDRESS	DATE OF BIRTH	SOCIAL SECURITY NUMBER	EMERGENCY CONTACT PHONE: ()
CITY, STATE, ZIP	SEX (M or F) M F	MARITAL STATUS Married Single Other	EMERGENCY CONTACT RELATION:
EMPLOYER NAME & ADDRESS	OCCUPATION	PATIENT ID (Office Use Only)	ALLERGIC TO ANY MEDS? :

Responsible Party

RESPONSIBLE PARTY NAME (First Name, Middle Initial, Last Name)	HOME PHONE ()	WORK or OTHER PHONE ()
ADDRESS	DATE OF BIRTH	SOCIAL SECURITY NUMBER
CITY, STATE, ZIP	SEX (M or F) M F	PATIENT'S RELATION TO RESP
EMPLOYER NAME & ADDRESS	OCCUPATION	RESP PARTY ID (Office Use Only)

Primary Insurance

INSURED'S NAME (First Name, Middle Initial, Last Name)	INSURED'S HOME PHONE ()	INSURED'S WORK PHONE ()
INSURED'S ADDRESS	INSURED'S DATE OF BIRTH	INSURED'S SOCIAL SECURITY NO.
INSURED'S CITY, STATE, ZIP	INSURED'S SEX (M or F) M F	INSURED'S RELATION TO PATIENT
INSURED'S EMPLOYER	INSURED'S OCCUPATION	
INSURANCE COMPANY NAME	INSURED'S ID #	
INSURANCE COMPANY ADDRESS	INSURED'S GROUP #	
INSURANCE COMPANY CITY, STATE, ZIP	INSURANCE COPAY AMOUNT	

Secondary Insurance

INSURED'S NAME (First Name, Middle Initial, Last Name)	INSURED'S HOME PHONE ()	INSURED'S WORK PHONE ()
INSURED'S ADDRESS	INSURED'S DATE OF BIRTH	INSURED'S SOCIAL SECURITY NO.
INSURED'S CITY, STATE, ZIP	INSURED'S SEX (M or F) M F	INSURED'S RELATION TO PATIENT
INSURED'S EMPLOYER	INSURED'S OCCUPATION	
INSURANCE COMPANY NAME	INSURED'S ID #	
INSURANCE COMPANY ADDRESS	INSURED'S GROUP #	
INSURANCE COMPANY CITY, STATE, ZIP	INSURANCE COPAY AMOUNT	

Authorization and Acknowledgement

I / We hereby state that the above information is true and correct to the best of my / our knowledge. I / We authorize the above named practice to release any information acquired in the course of my treatment to my insurance company, employer, Physicians, institutions or third party payers, as required for certain claims filed.

Signature of Patient / Parent / Guardian

Printed Name

Date

I / We authorize direct payment to be made to the above named practice for any and all medical or surgical services rendered. I understand if any services or charges are not covered by my insurance carrier or my eligibility can not be verified, I am responsible for all charges incurred.

Signature of Patient / Parent / Guardian

Printed Name

Date

FOR OUR MEDICARE PATIENTS: This office accepts Medicare assignment. Medicare pays 80% of the amount they approve after you have met your deductible. You are responsible for your deductible and the remaining 20%. If you have insurance that covers the remaining 20%, please provide us with that information.