# Comprehensive Gastroenterology

## REGISTRATION FORM

(Please Print Clearly and Complete ALL Fields)

**Primary Care Physician:** | Today's Date:

### PATIENT INFORMATION

Patient's last name: | First: | Middle: | ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. | Marital status (circle one) Single / M / D / Sep / W

Is this your legal name? ☐ Yes ☐ No | If not, what is your legal name? | E-mail address for patient portal: | Birth date: / / | Age: | Sex: ☐ M ☐ F

Street address: | City and State: | Zip Code:

SS #: - - | Preferred contact # where messages can be left: ( ) | Employment Status and Employer Name: Full Part Retired Self

Employer phone #: | Preferred Communication: Email Phone USPS Mail Patient Portal (must provide email address) | Would you like to receive text appointment alerts? Yes No

Preferred Language: | Race: Decline | Ethnicity: Decline | Referred By:

Pharmacy Name, Address and Phone #: ( MUST PROVIDE ALL INFORMATION )

### INSURANCE INFORMATION

☐ SELF PAY PATIENT CHECK BOX-NO INSURANCE WILL BE FILED

Primary Insurance Name:

Subscriber's name: | Birth date of cardholder: / / | Group no: | Policy / ID #:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary insurance (if applicable): | Subscriber's name and date of birth: | Group no: | Policy / ID #:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

### IN CASE OF EMERGENCY OR IF UNABLE TO REACH PATIENT

(If the office is unable to reach you at main number, this person may be contacted)

Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone #: ( ) | Work phone #: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Comprehensive Gastroenterology PA and/or insurance company to release any information required to process my claims.

*Patient/Guardian signature* *Date*