Mid-Valley Gastroenterology Associates

## PATIENT INFORMATION

| PATIENT'S LEGAL NAME<br>LAST | FIRST | MIDDLE INITIAL | SEX<br>M F | DATE OF BIRTH<br>/ / | AGE |
|---|---|---|---|---|---|
| MARITAL STATUS<br>S M W D SEP | SOCIAL SECURITY # | | CELL #<br>( ) | HOME #<br>( ) | |
| STREET ADDRESS | | | CITY & STATE | | ZIP CODE |
| EMPLOYED BY OR RETIRED FROM | ☐ ACTIVE<br>☐ RETIRED | | EMPLOYER ADDRESS | | EMPLOYER PHONE #<br>( ) |
| REFERRED BY | ADDRESS | CITY / STATE / ZIP | | | PHONE NUMBER<br>( ) |
| **FAMILY DOCTOR** | **ADDRESS** | **CITY / STATE / ZIP** | | | **PHONE NUMBER**<br>( ) |
| DO YOU HAVE INSURANCE THROUGH SPOUSE? | ☐ YES<br>☐ NO | SPOUSE'S NAME | SOCIAL SECURITY # | | DATE OF BIRTH<br>/ / |
| SPOUSE'S EMPLOYER | | | | | ☐ ACTIVE<br>☐ RETIRED |
| ADDRESS | CITY / STATE / ZIP | | | | SPOUSE'S EMPLOYER PHONE #<br>( ) |
| **DO YOU HAVE ANY OF THE FOLLOWING:**<br>**CARDIAC STENTS** ☐ **YES** ☐ **NO** | | | **PACEMAKER / DEFIBRILLATOR** ☐ **YES** ☐ **NO** | | |
| **NAME OF CARDIOLOGIST** | | | | | **PHONE NUMBER**<br>( ) |

## EMERGENCY INFORMATION: **(SOMEONE NOT LIVING IN YOUR RESIDENCE)**

Emergency Contact Person: _____

Relationship: _____ Telephone Number: ( ) _____

I hereby authorize release of any information concerning my healthcare, advice and treatment provided for the purpose of evaluating and administrating claims for insurance benefits. I also hereby authorize payment of insurance benefits, otherwise payable to me directly to the physician. I understand and I am responsible for any charges for services rendered not covered by insurance and applied deductibles or co-insurances.

**Signature:** _____ **Date**: _____

PATIENT