Gastroenterology Specialists of Dekalb, LLC

PATIENT REGISTRATION

Welcome to our office. In order to serve you properly, we will need the following information. **(Please Print)**
All information will be strictly confidential. Also, please provide the receptionist a picture id and your insurance card

Patient's Name	Sex M F	Birth Date ____/____/_____ Age_____	Patient's Social Security #
Address City State		Zip	Home Phone:
Person financially responsible for this account	Self Spouse Parent	Responsible Party's Birthdate if not self ____/____/_____	Responsible Party's Social Security (if different)#
Name of employer Address		Business Phone	How long at current Employer?
Email:		Occupation	
Responsible Party Drivers License State: Number:			Marital Status Single **[ ]** Married **[ ]** Widowed [ ] Divorced [ ]

Name of Spouse/Parent	Spouse Birthdate	Spouse Social security #	Spouse Business phone
Referring Physician and Phone Number:		Pharmacy Name Address & Phone Number	
Person to contact in case of emergency:	Relationship to patient	Phone	

Medicare Yes ✓ ✓ No **[ ]**	Medicare #	Medicaid Yes **[ ]** No **[ ]**	Medicaid #	Effective Date
Medicare Secondary insurance name Address			Policy #	Group #

Primary insurance company Address				Is insurance through your employer?
Subscriber Name	Subscriber birth date	Policy #		Group #
Secondary insurance name Address			Policy #	Group #

Medicare/Medicaid Signature on File:

I request that payment of authorized Medicare benefits be made on my behalf to Gastroenterology Specialists of Dekalb, LLC for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information to determine these benefits payable for related services

_____ _____
Patient Signature Date

Private Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned authorize payment of medical benefits to Gastroenterology Specialists of Dekalb, LLC for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

_____ _____
Patient, Parent or Guardian Signature (if child is under 18 years old) Date