Face Sheet

Please answer all questions fully

Date:

Gastroenterology Associates
931 Hallock Avenue
Port Jefferson Station, NY 11776
PH: (631)331-7200
Fax: (631)331-8636

Account Number:

Patient:				
Name (Last, First, MI)	Social Security	Age	DOB	Sex
Mailing Address:	City	State	Home phone	
			Cell phone	
			Work phone	
Employer	City	State	Marital Status	
			E-mail	

Responsible Party				
Name (Last, First, MI)	Social Security	Age	DOB	Sex
Mailing Address:	City	State	Home phone	
			Marital Status	
Employer	City	State	Work phone	

Primary Provider	Referring Provider	Address	Phone

Insurance Information				
Primary Insurance Company	Subscribers Name, DOB, SSN	Relationship	Policy #/Group #	Copay
Second Insurance Company	Subscribers Name, DOB, SSN	Relationship	Policy #/Group #	Copay
Third Insurance Company	Subscribers Name, DOB, SSN	Relationship	Policy #/Group #	Copay

Emergency Contact Information			
Contact Name	Primary Phone	Secondary Phone	Relationship

Please list additional medical information

Patient Release: I certify that the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare), for purpose of filing and payment medical claims. I authorize payment of medical benefits to the provider. I ACKNOWLEDGE THAT INTEREST OR A FEE, AT THE PROVIDERS CURRENT RATE, MAY BE CHARGED on all balances owingto the provider that are past due.

I permit a copy of this release to be used in place of the original

Signature: _____ Date: _____

(Signature of insured or authorized person, patient or parent of minor)