Gastroenterology Consultants Southwest, L.L.P.

Patient Registration

Last Name: ______________________________ First Name: __________________Middle Initial: __________

Sex: _____ Date of Birth: ___________________ Age: ______ Marital Status: _______

Race: American Indian or Alaskan ___ Asian ___ Black or African American ___ Native Hawaiian or Pacific Islander ___

White ___ Patient Refusal ___

Ethnicity: Hispanic or Latino ___ Not Hispanic or Latino ___ Patient Refusal ___

Primary Language:________________________ Secondary Language:_______________________________________

Patient's Social Security No:___________________________ Home Phone No: _________________________________

Patient's Mobile Phone No: ____________________________ Work Phone No: ___________________________________

Address: ____ Apt. No. ______________

City: ____ State: __________ Zip Code: _____________________

Patient's Employer: ____

Employer Address: ____

City: ____ State: ___________ Zip Code: ___________________

Spouse's Name: ____ Date of Birth: ________________________

Spouse's Work Number ____Spouse's Mobile No:______________________

Name of physician that ***REFERRED*** you to our office: ____

REFERRING physician address: ____

City __________________________ Zip Code: ________________ Phone Number: ___________________________

Name of ***PRIMARY CARE*** physician: ____

PRIMARY CARE physician address: ____

City __________________________ Zip Code: ________________ Phone Number: ___________________________

Emergency Contact Name (Not living with you): ____

Home Phone Number: ________________________________ Work Phone Number: ___________________________

Pharmacy Phone No:________________________

Pharmacy Address____

PRIMARY Insurance Company: ____

Name of Insured:___________________________ Relationship____________ Date of Birth:_____________

Subscriber ID No:_______________________ Group #__________________________

Insured Social Security No: ________________________ Insurance Phone No:______________________

Insurance Company Address:____

Employer Name: _______________________________Employer phone No:________________________

SECONDARY Insurance Company:____

Name of Insured:___________________________ Relationship_____________ Date of Birth: ____________

Subscriber ID No:_______________________ Group #__________________________

Insured Social Security No: ________________________ Insurance Phone No:______________________

Insurance Company Address:____

Employer Name: _______________________________Employer phone No:________________________

I hereby authorize my insurance benefits to be paid directly to the physician, realizing I am responsible to pay non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers.

Patient's Signature: ____Date: ________________________

I hereby authorize Gastroenterology Consultants SW, LLP to release medical and/or billing information to:

Name:__________________________________ Relationship:___________________________

Name:__________________________________ Relationship:___________________________

Name:__________________________________ Relationship:___________________________

Patient Refusal________

Patient's Signature: ____Date: ________________________

Updated 4/25/11