Patient # _______________

____
Staff Initials

REGISTRATION FORM

PLEASE PRINT Patient's Full Legal Name

____
Last First Middle

Other names we may have treated you under______________________ Social Security # ______ - ______ - ______

Mailing Address____

City ____________________________ State _______ Zip ________________

Home Phone (_____)__________________ Cell Phone (_____)________________ Work (_____)____________________

Preferred method of contact (please circle one) Home Cell Work Portal Decline to specify

E-mail Address:____ Sex (circle) Male / Female / Other

Date of Birth __________/_________/______________ Age ___________________

Family Doctor _______________________________________ Referred by ____________________________________

Employer Name ____
Name Address Phone #

Is Patient Retired (circle) Yes / No Date of Retirement _______________________________

Race (circle) White / African American / Asian / American Indian Other: _________________________

Are you Hispanic or Latino: Yes / No What is your preferred language? _______________________________

Marital Status (circle) Single / Married / Divorced / Widowed

Spouse's Name __________________________________ Spouse's Date of Birth _____________________________

Emergency Contact Person ____ ___________________________
Full Name Relationship

(_______)______________________ (_______)________________________ (_______)________________________
Home Phone Mobile Phone Work phone

IS ANYONE OTHER THAN THE PATIENT RESPONSIBLE FOR THE ACCOUNT? (circle) Yes / No

* If patient is a minor, student or has a legal healthcare and/or financial power-of-attorney (If power-of-attorney, please provide legal documentation)

Guardian name ____

Relationship to patient _______________________________________ Date of Birth ________/_________/___________

Address & phone if different from patient ____

____

City ____ State ___________ Zip ______________________

(_______)_____________________ (_______)______________________ (_______)________________________
Home Phone Work Phone Mobile Phone

I understand that Associated Gastroenterology Consultants, Inc. will file my insurance/supplemental health insurance claim form for me. I authorize payment of insurance benefits to be made to Associated Gastroenterology Consultants, Inc. for medical services rendered. I also understand that I am financially responsible for any copayment(s), deductible(s), coinsurance and/or balance from non-covered services that is owed to Associated Gastroenterology Consultants, Inc. for services rendered. This authorization will remain in effect until revoked by me in writing.

SIGNATURE ____ **DATE** _______________________

If not the patient please describe relationship ____ rev 2/22