Chart #__________

PATIENT DEMOGRAPHICS

Indiana Gastroenterology, Inc. / www.indianagastro.com

Please Print Clearly

Name____ **Date of Birth**____________**Soc. Sec. #**__________________
(Last) (First) (M.I.) (MM/DD/YYYY)

Gender (circle one) M / F **Marital Status** (circle one) S M D W Sep **Race**_______________ **Ethnicity**______________

Email______________________________________ **Preferred Language**____

Address____
(Street) (City) (State) (Zip Code)

Home Phone (____) _______________ **Cell Phone** (____) _______________ **Work Phone** (____) _______________

Patient / Guardian Employer____

Employer Address____
(Street) (City) (State) (Zip Code)

Primary Care Physician____
(Name) (Location) (Phone #)

Referring Physician ***(if different from above)***____
(Name) (Location) (Phone #)

In addition to your physicians, with whom may we discuss your health information?_________________________________

Emergency Contact____
(Name) (Relationship to Patient) (Phone #)

Place a check mark in the box next to the following at which we may leave health information

☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Email

PRIMARY Insurance Name_________________________________ **Name of Policyholder**______________________________

Policyholder Date of Birth______________ **Policyholder SS#**__________________

Policyholder employer____________________________________ **Policyholder relationship to patient**____________________

SUPPLEMENTARY Insurance Name_________________________ **Name of Policyholder**______________________________

Policyholder Date of Birth______________ **Policyholder SS#**__________________

Policyholder employer_____________________________________ **Policyholder relationship to patient**__________________

PLEASE PRESENT ALL INSURANCE CARDS TO RECEPTIONIST FOR COPYING

PLEASE READ AND SIGN BELOW

I hereby authorize my insurance benefits to be paid directly to **Indiana Gastroenterology, Inc.**, realizing that I am responsible to pay non-covered services. I also realize that I am ultimately responsible for meeting all requirements or stipulations my insurance company may have regarding referrals, certification, notification, and designated facilities or physicians. I realize that **Indiana Gastroenterology, Inc.** will file my insurance claims on my behalf but that any mediation or follow up with my insurance carrier is my responsibility. I hereby authorize release of pertinent medical information to my insurance carriers. I understand that co-payment or payment of non-covered services is due at the time of service.

Signature____**Date**______________________