

NORTH SHORE GASTROENTEROLOGY & ENDOSCOPY CENTER, INC.
PATIENT REGISTRATION FORM

Patient Information

Patient Name _____

Address _____

City _____ State _____ Zip Code _____

Male Female Date of Birth _____ Social Security Number _____

Check one: Married Single Divorced Widowed Occupation: _____

Home Phone _____ Cell Phone _____ Work Phone _____

Referring Physician _____ **Primary Care Physician** _____

Primary Insurance _____ Secondary Insurance _____

Insurance Card Holder Information

Name _____

Relationship to Patient Self Spouse Parent Guardian Other _____

Birthdate _____ Social Security Number _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer: _____

Employer Address _____

Employer City/State/Zip _____

I authorize the above practice(s) to disclose any or all information relating to my visit, including copies of my diagnostic test results, to or from my attending physician and or other physicians selected by my attending physician, at his or her discretion for the purpose of obtaining further diagnosis and/or treatment which he or she believes is indicated.

I authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the doctor or group indicated on the claim. I am responsible for any referrals and/or authorizations required by my insurance company.

I understand that I am financially responsible for any balance not covered by my insurance. I understand that the above Practice(s) are not responsible for collecting on an insurance claim or negotiating a settlement on a disputed claim. I agree that I am responsible for any co-payments, deductibles and fees for non-covered services.

I understand that the above practice(s) are not in the business of extending credit and I agree to pay the above practice(s) at the time its bills are presented. If prompt payment is not made, the above practice(s) may take action to collect its charges.

I have received a copy of the Notice of Privacy Practices for North Shore Gastroenterology and Endoscopy.

I do not want to receive a copy of the Notice of Privacy Practices for North Shore Gastroenterology and Endoscopy.

Can we leave a message at your home phone? Yes No

List any family member(s) or friend(s) that we can discuss your information with _____

Emergency contact name: _____ Phone: _____

Patient Signature _____ **Date** _____