# Gastrointestinal Surgical Specialists, LLC

## Patient Information

Patient's Name (Last, First, MI)_____ Date of Birth _____

Address _____ City _____County_____ State ____ Zip _____

Social Security Number _____-_____-_____ Home Phone (____) _____ Cell (____)_____

Circle: Male / Female  Marital Status S/ M/ W/ D  Referring/Family Physician _____

Employer _____ Work Phone (_____)_____ ext._____

## Insurance Information

**Primary Insurance Company** _____

Insured's Name (Last, First, MI) _____

Insured's SSN _____-_____-_____ Date of Birth_____ Relationship to Patient _____

Policy Number _____ Group Number _____

**Secondary Insurance Company** _____

Insured's Name (Last, First, MI) _____

Insured's SSN _____-_____-_____ Date of Birth _____ Relationship to Patient _____

Policy Number _____ Group Number _____

**Other Insurance Company** _____

Insured's Name (Last, First, MI) _____

Insured's SSN _____-_____-_____ Date of Birth _____ Relationship to Patient _____

Policy Number _____ Group Number_____

## Emergency Contact Information

Name _____ Relationship_____

Phone Number- ( _____) _____

# MEDICAL RELEASE AUTHORIZATION

**I, the undersigned patient, or my authorized representative**, hereby authorize my physician and whomever he or she may designate as his/her assistant to render medical treatment to me. I consent to any medical care that encompasses laboratory, diagnostic, or medical treatment which my physician, including his/her assistant, may deem necessary during my office visit.

**I, the undersigned patient, or my authorized representative**, hereby authorize my physician and whomever he or she may designate as his/her assistant to release any medical information accumulated in the course of my examination and treatment any other doctor, hospital or other parties assisting in my medical care.

**I, the undersigned patient, or my authorized representative**, hereby authorize the release of, and request payment of, benefits to be paid to GI Surgical Specialists, LLC, when they accept assignment of benefits. I authorize use of a Photostat copy of this assignment of benefits in lieu of the original when necessary.

**I, the undersigned patient, or my authorized representative**, hereby authorize the release of any medical information necessary to process my insurance claims and request payment of benefits either to me or the party who accepts assignment of benefits.

**I understand that I am responsible for any charges not covered by any insurance, such as, but not limited to, co-payments and deductibles.**

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**Patient/Legal Representative Signature** **Date**

Legal Representative Relationship to Patient _____

# SOCIAL SECURITY ADMINISTRATION

If you have health coverage through Medicare, please sign this authorization.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, any information needed for this or any related Medicare claims. I permit a copy of this authorization to be used in lieu of the original, and request payment of medical insurance benefits either to me or to the party who accepts assignment of benefits. I under it is mandatory to notify the health care provider or any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 USC 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare Assignment of Benefits also apply.

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**Patient/Legal Representative Signature** **Date**

Legal Representative Relationship to Patient _____

***PLEASE PROVIDE INSURANCE CARDS AND DRIVERS LICENSE OR OTHER PICTURE ID***