FGA | FREDERICK GASTROENTEROLOGY ASSOCIATES

Patient Name_____
Last First Middle

Home Address _____
Street City State Zip

Home Phone_____ Daytime/Wk Phone_____Cell Phone_____

Sex: M__F__ Age:_____ Date of Birth _____ Primary Care Doctor _____

Marital Status: S__ M__ D __ W__ Email address_____ Soc Sec # _____

Insurance No.1_____ Subscriber_____ _____
Plan Name **Date of Birth**

Subscriber's Social Security # _____

Is Insurance through: Employer___ Your Spouse ___ Parent/Other ___ Co-Pay Amount: $_____

Insurance No.2_____ Subscriber_____ _____
Plan Name **Date of Birth**

Subscriber's Social Security # _____

Is Insurance through: Employer___ Your Spouse ___ Parent/Other ___ Co-Pay Amount: $_____

Person to notify in case of an emergency: Name _____

Daytime Phone: _____ Relationship to Patient: _____

Evening Phone: _____ Cell Phone: _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMANT OF BENEFITS

I request the payment of insurance benefits (including Medicare benefits) be made on my behalf to Frederick Gastroenterology Associates and their physicians for any services furnished to me. I authorize the use of my Protected Health Information (PHI) for payment, treatment and/or Health Care Operations. Either my insurance carrier or I may revoke this authorization at any time in writing. I accept responsibility for any and all charges not paid by my insurance.

_____ _____ _____
Signature Print Name Date

I acknowledge Receipt of Frederick Gastroenterology Associates Notice of Privacy Practices

_____ _____ _____
Signature Print Name Date

Revised 8/14//14