

Patient Information Sheet

_____ LAST NAME	_____ FIRST NAME	_____ MIDDLE NAME	_____ SEX
_____ BIRTH DATE	_____ SOCIAL SECURITY NUMBER	_____ REFERRING PHYSICIAN	
_____ PATIENT'S ADDRESS	_____ CITY	_____ STATE	_____ ZIP CODE
_____ HOME PHONE	_____ WORK PHONE	_____ MOBILE PHONE	
_____ EMERGENCY CONTACT PERSON	_____ EMERGENCY CONTACT NUMBER		

Insurance Information

_____ NAME OF EMPLOYER	_____ EMPLOYER'S ADDRESS
_____ PHONE NUMBER OF EMPLOYER	_____ CITY, STATE, ZIP CODE

Primary Health Insurance:

_____ PRIMARY INSURANCE NAME	_____ POLICY NUMBER
_____ NAME OF POLICY HOLDER	_____ RELATIONSHIP TO PATIENT
_____ POLICY HOLDER'S DATE OF BIRTH	_____ POLICY HOLDER'S SSN

Secondary Health Insurance:

_____ SECONDARY INSURANCE NAME	_____ POLICY NUMBER
_____ NAME OF POLICY HOLDER	_____ RELATIONSHIP TO PATIENT
_____ POLICY HOLDER'S DATE OF BIRTH	_____ POLICY HOLDER'S SSN

ALL INSURANCE INFORMATION MUST BE COMPLETE AND ACCURATE

Missing or inaccurate information will result in NON-PAYMENT from you insurance company

Primary and secondary insurances will be billed as a courtesy by this office. Payment of benefits will be made to Fayetteville Gastroenterology Associates, P.A. for services rendered. Should your insurance company refuse payment you will be notified. Patients notified of nonpayment are expected to contact their insurance company to resolve any problems.

YOU MUST BRING YOUR INSURANCE CARDS TO EVERY APPOINTMENT

I understand that I will pay any deductible and/or co-payment at the time of service. Your insurance company determines this amount.

Patient /Responsible party signature _____ Date _____