

Patient Information Form

Patient information – (PLEASE PRINT)

Name _____ Email address _____
LAST FIRST MI.

SS# _____ Date of Birth ____ / ____ / ____ Sex: M / F Marital Status S M W D Sep

Address _____
STREET CITY STATE ZIP CODE HOME PHONE CELL PHONE

Employer _____ Occupation _____ Race _____

Address _____
STREET CITY STATE ZIP CODE WORK PHONE

Family Dr. _____ Referred by _____
STREET CITY STATE ZIP CODE PHONE

Has any member of your immediate family been treated by our physician(s) before? If so, who? _____

Who may we discuss your medical information with besides you? Name _____ Relationship _____

Spouse / Responsible Party

Name _____ Relationship _____
LAST FIRST MI.

Employer _____ Address _____
STREET CITY STATE ZIP CODE

Emergency / Alternate contact

Name _____ Relationship _____ Phone _____ work/cell _____

Primary Insurance Information

Policyholder Name _____ Date of Birth ____ / ____ / ____ SS# _____

Insurance Name _____ Policy# _____ Group# _____

Address _____
STREET CITY STATE ZIP CODE

Employer Name _____ Relationship to Policyholder: SELF SPOUSE CHILD OTHER

UPDATE:	
Date	Initials

Secondary Insurance Information

Policyholder Name _____ Date of Birth ____ / ____ / ____ SS# _____

Insurance Name _____ Policy# _____ Group# _____

Address _____
STREET CITY STATE ZIP CODE

Employer Name _____ Relationship to Policyholder: SELF SPOUSE CHILD OTHER

Current Medications - include prescription, over the counter and herbal supplements (Please include name, dose and frequency)

Pharmacy

NAME _____ STREET _____ PHONE # _____

Allergies:

I hereby authorize Gastrointestinal and Liver Diseases Consultants and/or Endoscopy Centers of Dayton to use and/or disclose my health information to carry out my treatment, obtain payment and conduct healthcare operations. I understand this consent is voluntary. I have been informed that Gastrointestinal and Liver Diseases Consultants and/or Endoscopy Centers of Dayton have a Notice of Privacy Practices, which fully describes how they will use and disclose my health information and that a copy of this notice is posted in the waiting room and that there are copies available for my review. I understand that the physicians of Gastrointestinal and Liver Diseases Consultants and/or Endoscopy Centers of Dayton have a financial interest in the Endoscopy Centers of Dayton, and that I have the option to choose another healthcare facility for procedures. I hereby authorize payment of medical benefits that are billed to my insurance to Gastrointestinal and Liver Diseases Consultants and/or Endoscopy Centers of Dayton. I accept responsibility for payment for services provided to me that are not covered by my insurance.

***By providing the information on this form you are authorizing us to contact you and/or leave messages at the numbers provided.**

Signature _____ (Patient or guardian if minor) Date _____