

**Patient Information Form**

Please **PRINT** all information in the spaces provided unless a signature is required. Be sure to read and complete the statement on the back of this form.

Patient's Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_

Address \_\_\_\_\_  
mailing address city state zip code

If mailing address is P.O. Box, what is your physical address? \_\_\_\_\_

Email Address \_\_\_\_\_ Employer \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Ext \_\_\_\_\_

Cell phone \_\_\_\_\_ Marital status: Single Married Other (legally sep; divorced, widowed)

Date of birth \_\_\_\_\_ Social security number \_\_\_\_\_ Male Female

**Insurance Coverage Information** (Please present card in order that a copy will be on file at this office.)

**Primary Insurance Company Name** \_\_\_\_\_

Name of insured/relation to patient \_\_\_\_\_ Insured's Date of Birth \_\_\_\_\_

Address/phone number of insured if different from above \_\_\_\_\_

**Secondary Insurance Company Name** \_\_\_\_\_

Name of insured/relation to patient \_\_\_\_\_ Insured's Date of Birth \_\_\_\_\_

Address/phone number of insured if different from above \_\_\_\_\_

**Tertiary Insurance Company Name** \_\_\_\_\_

Names of insured/relation to patient \_\_\_\_\_ Insured's Date of Birth \_\_\_\_\_

Address/phone number of insured if different from above \_\_\_\_\_

**Referring Physician's Full Name** \_\_\_\_\_

**Primary Care Physician's Full Name** (if different from referring physician) \_\_\_\_\_

**Emergency contact and telephone number** \_\_\_\_\_

I hereby authorize payment of medical benefits billed to my insurance to Athens Gastroenterology Center, P.C./Gregory S. Smith, M.D. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance, if the Practice does not participate with my insurance.

**I agree to pay all copayments, if any, at the time the service is rendered.** This practice accepts cash, personal checks, money orders, VISA, and MasterCard.

\_\_\_\_\_  
Signature of patient or guardian

\_\_\_\_\_  
Date

**Please turn page over**

**CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT, ASSIGNMENT OF BENEFITS, AND HEALTH CARE OPERATION**

I, \_\_\_\_\_, hereby authorize Athens Gastroenterology Center, P. C. to use/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment, and health care operations.

**TREATMENT AUTHORIZATION:** I authorize you to give me reasonable and proper medical treatment by today's standards.

**RELEASE OF INFORMATION:** I release all of my medical records to Athens Gastroenterology Center, P.C., including human immunodeficiency virus, psychiatric, drug/alcohol abuse records, venereal disease, and any other statutory protected disease, as necessary for continued medical care, to obtain insurance reimbursement, or to comply with utilization review. I authorize this office to obtain previous medical records from other physician and/or medical facilities.

**MEDICAL LIFETIME SIGNATURE ON FILE: (IF APPLICABLE):** I request that payments of authorized Medicare benefits be made to Athens Gastroenterology Center, P.C./Gregory S. Smith, M.D. for any services furnished. I authorized any holder of medical information about me to release to the Health Care Finance Administration and its agent any information needed to determine these benefits or benefits payable for related services.

**ASSIGNMENT OF BENEFITS:** I request that payment of authorized insurance benefits be made on my behalf to Athens Gastroenterology Center, P.C.

**FINANCIAL RESPONSIBILITY:** I understand that Athens Gastroenterology Center, P.C. will file my insurance as a courtesy to me and that I remain responsible for payment of copays, deductibles, non-covered services, and any other charges not paid by insurance within 45 days.

\_\_\_\_\_  
Signature of patient or patient's representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of patient or patient's representative

\_\_\_\_\_  
Relationship to patient