GASTROENTEROLOGY ASSOCIATES
KINGSPORT ENDOSCOPY CORPORATION
THE ENDOSCOPY CENTER OF BRISTOL, LLC

Patient Information

DATE: _____ **ACCOUNT NO.** _____ **DATE OF BIRTH** _____

Patient's Last Name First MI Home Phone Work/Business Number

Address City County State Zip Code Cell Phone Number

Social Security Number _____ Sex Male ___ Female ___ (Check One) ___ Married ___ Single ___ Divorced ___Widowed

Employer Name Employer Address Employer Phone Number

Spouse's Name Spouse's Employer Spouse Employer's Phone

Spouse's Date of Birth Spouse's Social Security #

E-Mail Address Race: African American Asian Caucasian Native American Other

PERSON RESPONSIBLE FOR ACCOUNT

Last Name First MI Relationship to Patient

Address City State Zip Code

Social Security Number Home Phone Work/Business Phone Birth Date Sex { } Male { } Female

Employer Name Employer Address

Employer Phone Number Contact Person

INSURANCE INFORMATION

PRIMARY INSURANCE	*SECONDARY INSURANCE*	*THIRD INSURANCE*
Claims Address	Claims Address	Claims Address
Insurance Phone Number	Insurance Phone Number	Insurance Phone Number
ID Number	ID Number	ID Number
Group Number	Group Number	Group Number
Subscriber Social Security #	Subscriber Social Security #	Subscriber Social Security #
Patient's Relationship to Subscriber	Patient's Relationship to Subscriber	Patient's Relationship to Subscriber

IN CASE OF EMERGENCY CONTACT (*OTHER THAN PATIENT'S HOME NUMBER*)

Name Home Number Work or Business Number Relationship to Patient

Do you have a living will?_____ YES _____ NO. If so, please bring a copy with you to your next visit.

Referring Physician: _____ **If not referred by Physician, how did you hear about us?**

Family Physician: _____ **Pharmacy Name/Phone** _____

ARE YOU ALLERGIC TO ANY MEDICATION? ____YES ____ NO. If so, which ones? _____

PLEASE COMPLETE BOTH SIDES OF THIS FORM

Privacy Acknowledgement

1 May we call the telephone number you provided and leave a message on an answering machine or with a family member/friend regarding your appointment or test results? ____ YES ___ NO. If **NO**, is there another number at which we may try to reach you? Area Code: _____ Phone Number: _____
May we call you at work _____YES Work Phone Number: _____
_____ NO

2 May we mail to your home address information regarding your appointment or test results? _____ YES _____NO
If **NO**, is there another address to which we may send your information? Please provide that mailing address:

_____

3 Please list a family member(s) with whom we may release your medical information if needed:

NAME	AREA CODE & PHONE NUMBER	RELATIONSHIP

I have received a copy of the Physician's Practice "Notice of Privacy Practices for Protected Health Information".

_____ _____
Signature Date

INSURANCE INFORMATION

Patient and/or guarantor is responsible for charges incurred. It is a courtesy of our office to file your insurance; however you are responsible for your co-pay and/or percentage, which the insurance company is not liable for on the day of your visit. If we are unable to obtain payment payment within a reasonable amount of time from the patient and/or guarantor, we will place your account with a collection agency, which will leave you liable for additional expenses incurred if applicable.

I have read and understand the above statement of payment policy. I hereby request any benefits on my behalf be paid to the physicians. I also authorize the release of any information required in the course of my treatment to my insurance company as needed to issue benefits. I authorize the physicians to administer such treatment they may deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by the physician and nurse practitioner and I consent to care by such providers. I understand that these services are voluntary and that I have the right to refuse these services

_____ _____
Signature Date

_____ _____
Witness Date

I request that payment of authorized Medigap (Medicare Supplement) benefits be made on my behalf to the provider for services furnished me by that provider. I authorize any holder of medical information about me; to release to Medigap Insurer _____ _____ any information needed to determine these benefits payable for released services.

_____ _____
Signature Date

MEDICARE "B" SIGNATURE AUTHORIZATION

I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carriers, or to the billing agent of this physician or supplier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the party who accepts assignment.

I understand that this is a lifetime authorization.

_____ _____
Signature Date

PLEASE COMPLETE BOTH SIDES OF THIS FORM