# PATIENT REGISTRATION FORM

| PATIENT INFORMATION | RESPONSIBLE PARTY |
|---|---|
| First Name MI Last Name | First Name MI Last Name |
| Mailing Address | Mailing Address |
| City State Zip | City State Zip |

| Date of Birth | Sex [ ] M [ ] F | Marital Status S M D W |
|---|---|---|

Race: [ ] American Indian [ ] Asian [ ] Black or African American [ ] Native Hawaiian or Pacific Islander [ ] Caucasian [ ] Other Race [ ] Declined/Unavailable

Ethnicity: [ ] Non Hispanic [ ] Hispanic [ ] Declined/Unavailable

SS# Referring Physician

Home Phone # Work Phone # Cell Phone #

Email Address Would you like to receive Email from us? [ ] Yes [ ] No

Employer Name

Number you would prefer us to call? [ ] Home [ ] Work [ ] Cell Can we leave a message? [ ] Yes [ ] No

Emergency Contact
Name ________________________________ Phone Number __________________________ Relationship __________________________

Pharmacy Name and Number

## INSURANCE INFORMATION

| Primary | Secondary |
|---|---|
| Insurance Company Name | Insurance Company Name |
| Policy Holder's Name | Policy Holder's Name |
| Policy Holder's Social Security Number | Policy Holder's Social Security Number |
| Policy Holder's Date of Birth | Policy Holder's Date of Birth |
| Policy Number | Policy Number |
| Group Number | Group Number |

❏ I hereby authorize my insurance benefits to be paid directly to Atlantic Gastroenterology, P.A. and/or Atlantic Gastroenterology Endoscopy Center, P.A. realizing that I am responsible to pay non-covered services.

❏ I also authorize the use and disclosure of my health information for purposes of treatment, payment and healthcare operations.

❏ I hereby give consent to healthcare providers of Atlantic Gastroenterology, P.A. and/or Atlantic Gastroenterology Endoscopy Center, P.A. to evaluate and render medical treatment.

## Privacy Practices Acknowledgement

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

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Patient or Patient Representative Signature Date Relationship to Patient