Northwest Ohio Gastroenterology Associates

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PATIENT INFORMATION

Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: (Home): _____ (Cell): _____ (Work): _____ (ext): _____

Email Address: _____

Date of Birth: _____ SS# ___ - ___ - ____ Age: _____

Sex: ◯ Male ◯ Female Race: _____

Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Widowed ◯ Separated

Patient Occupation: _____ Employer: _____

Family Doctor: _____ Address: _____ Phone: _____

Pharmacy: _____ Address: _____ Phone: _____

Referred By: _____ Have you ever been seen by our doctors? ◯ yes ◯ no

Spouse Name: _____ Spouse Date of Birth: _____ Spouse SS# ___ - ___ - ____

Spouse Telephone: _____ Employer: _____

Emergency Contact (Name): _____ (Relationship): _____ Phone#: _____

INSURANCE INFORMATION

Primary Insurance

Policy Holder: _____ Date of Birth: _____ SS# _____

Insurance Company: _____

Address for Claim Submission: _____

ID #: _____ Group #: _____

Address of Insured (if different than patient): _____

City: _____ State: _____ Zip Code: _____ Phone # _____

Secondary Insurance

Policy Holder: _____ Date of Birth: _____ SS# _____

Insurance Company: _____

Address for Claim Submission: _____

ID #: _____ Group #: _____

Address of Insured (if different than patient): _____

City: _____ State: _____ Zip Code: _____ Phone # _____

I request payment of authorized insurance benefits, including Medicare/Medicare supplements, be made on my behalf to Northwest Ohio Gastroenterology Associates/Northwest Ohio Endoscopy Center for any services furnished to me. I authorize the release of any medical information needed to determine payment of claims.

Signature: _____ **Date:** _____

CONSENT TO RELEASE MEDICAL INFORMATION

The undersigned hereby authorizes Northwest Ohio Gastroenterology Associates, Inc. and its employees and agents

____ to leave a message on my answering machine regarding my treatment at the following telephone number(s) _____.

____ to provide information either in person or via telephone regarding my treatment to (name(s)) _____.

The last four digits of social security # of the above named person(s) is/are

as follows: _____

I understand that by signing this release, I expressly consent to allowing Northwest Ohio Gastroenterology Associates, Inc. to convey confidential and sensitive information regarding my care and treatment either over an answering machine or to the specific person(s) named above. It is my express desire that such messages be left on my answering machine in my absence of provided directly in person or via telephone to the above named person(s) in my absence to expedite communication regarding my care and treatment. I hereby release Northwest Ohio Gastroenterology Associates, Inc. And its employees and agents from any liability associated with leaving such messages on the answering machine at the telephone number set forth above or providing such information to the above named person(s) either in person or via telephone.

Signature: _____ Date: _____

This authorization is valid until such time as it is revoked by the patient.