NEW PATIENT REGISTRATION

PATIENT REGISTRATION

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

Sex: Male / Female: _____

Address: _____

City/State: _____ Zip Code _____

Home Phone #: _____

Cell #: _____

Marital Status: _____

Email Address: _____

Employer: _____

Work phone: _____

Emergency Contact: _____

Phone Number: _____

Who referred you to our office? _____

INSURANCE/BILLING INFORMATION

PRIMARY Insurance Company: _____

Phone Number: _____

Name of Insured: _____

Date of Birth: _____

Policy or ID Number: _____

Group Name or Number: _____

Relationship to the patient: _____

Insured Date of Birth: _____

SECONDARY INSURANCE

Insurance Company: _____

Phone Number: _____

Name of Insured: _____

Date of Birth: _____

Policy or ID Number: _____

Group Name or Number: _____

Relationship to the patient: _____

Insured Date of Birth: _____

ASSIGNMENT INSURANCE BENEFITS

I hereby authorize direct payment of medical/surgical benefits to Vegas Gastroenterology for services rendered by him person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.

Patient Name (print): _____ Date: _____

Guardian Name (Print) : _____ Date: _____

Vegas Gastroenterology
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