JAY A. CHERNER, M.D.

A Division of

GASTROENTEROLOGY CONSULTANTS, P.C.

General Information

Today's date:________________ Nickname____________

Please print name as it appears on your insurance card

Patient Name (LAST):________________________ (FIRST)__________________ (Middle initial)___

Address: ____ City: ________________

State: _______ Zip: _____________ Patient's Social Security # (SSN): _____ / _____ / _______

Telephone Numbers: Home: _________________Cell:___________________ Work:_______________

Fax number (optional): _______________E-mail address (optional)____________________________

Date of Birth: ___________________ *Circle one*: MALE FEMALE Driver's License Number_________

Marital Status: ___Married ___Single ___Widowed ____Divorced ___Partnered

Spouse Name: _____________________________ Spouse Date of Birth________

Spouse Cell Phone:__________________________

Emergency contact (*not* living with you): __________________________

Relationship:_____________________ Cell Phone:_______________

Patient Employer: ________________________ Employer Address:_____________________________

City:____________________________ Zip:_________

Primary Insurance Co. (*Please list both name and address*):

____

ID#:____ Group #:______________________________

Policy Holder Name: __________________________________ Policy Holder Birth Date:______________

____

Secondary Insurance Co. (*Please list both name and address*):

____

ID#:____ Group #:_________________________

Policy Holder Name:_____________________________________ Policy Holder Birth Date: ____________________

REFERRED BY:____

PRIMARY CARE PHYSICIAN:____

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General Information

Patient's Name:____

INSURANCE AUTHORIZATION/ASSIGNMENT:
I hereby authorize **Gastroenterology Consultants, P.C.** to release necessary information to insurance carriers acquired in the course of my treatment.

Signature:____ *Date*:_________________________

I hereby assign payment of medical benefits for me or my dependent(s) to **Gastroenterology Consultants, P.C.**

Signature:____ *Date*:______________________

I hereby authorize payment of medical benefits billed to my insurance to ________________________. 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, coinsurance, and deductibles at the time the service is rendered.

I will pay by (check one): □ cash □ check □ credit card

_________________________________ _______________
Signature of patient or guardian *Date*