GASTRO HEALTH

PATIENT INFORMATION **Pt#:**

Name:	**Date of Birth:**
Address 1:	Social Security #:
Address 2:	Sex:
City:	Relationship: M S W D
State: Zip:	Employer:
Home Phone#:	Race:
Work Phone#:	Ethnicity#:
Cell Phone#:	Language:
Referring Physician:	Primary Care Physician:

GUARANTOR INFORMATION

Name:	Date of Birth:
Address 1:	Social Security#:
Address 2:	
City:	Employer:
State: Zip:	Employer Address:
Home Phone#:	Employer City:
Work Phone#:	Employer State: Zip:
Cell Phone#:	

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Certificate#:	Certificate#:
Group Number:	Group Number:
Group Name:	Group Name:
Copay:	Copay:
Subscriber 1 Name:	Subscriber 2 Name:
Subscriber Birthdate:	Subscriber 2 Birthdate:

Authorization: Pay Benefits to Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to my Provider at Gastro Health (Formerly Ohio GI and Liver Institute) when assignment is accepted. I understand that I am responsible for any amount not covered by insurance.

Authorization: Release Medical Information. I hereby authorize Ohio GI and Liver Institute to release any information necessary for my course of treatment.

I confirm that the above patient and insurance information is accurate.

_____ _____

Signed (patient or parent if minor) **Date**

Patient / Subscriber identification verified by: _____ **Date:** _____