

**PATIENT REGISTRATION INFORMATION**

Please PRINT AND complete ALL sections below!

Date: \_\_\_\_\_ Account # \_\_\_\_\_

Is your condition a result of a work injury? YES NO An auto accident? YES NO Date of injury: \_\_\_\_\_

**PATIENT'S PERSONAL INFORMATION**

Name: \_\_\_\_\_  
 Last Name First Name Middle Initial  
 Marital status: Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed \_\_\_ Sex: Male \_\_\_ Female \_\_\_  
 Street address: \_\_\_\_\_ Apt # \_\_\_\_\_ City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip: \_\_\_\_\_ Social Security # \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Home phone: ( ) \_\_\_\_\_ Cellular phone: \_\_\_\_\_  
 Email address: \_\_\_\_\_ Driver's License: (State & Number) \_\_\_\_\_  
 Employer/Name of School \_\_\_\_\_ Work phone: ( ) \_\_\_\_\_  
 Spouse's name: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_  
 Spouse's Work phone: ( ) \_\_\_\_\_

**PATIENT/RESPONSIBLE PARTY INFORMATION**

Responsible party: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Relationship to Patient: Self \_\_\_ Spouse \_\_\_ Other \_\_\_ Social Security # \_\_\_\_\_  
 Responsible party's home phone: ( ) \_\_\_\_\_ Work phone: ( ) \_\_\_\_\_  
 Address: \_\_\_\_\_ Apt # \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Employer's name: \_\_\_\_\_ Phone number: ( ) \_\_\_\_\_  
 Address: \_\_\_\_\_ Apt # \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**PATIENT'S INSURANCE INFORMATION**

Please present insurance cards to receptionist

PRIMARY insurance company's name: \_\_\_\_\_  
 Insurance address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Name of insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Relationship to insured: Self \_\_\_ Spouse \_\_\_ Child \_\_\_ Other \_\_\_ Insurance ID #: \_\_\_\_\_ Group # \_\_\_\_\_  
 SECONDARY insurance company's name: \_\_\_\_\_  
 Insurance address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Name of insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Relationship to insured: Self \_\_\_ Spouse \_\_\_ Child \_\_\_ Other \_\_\_ Insurance ID #: \_\_\_\_\_ Group # \_\_\_\_\_

**PATIENT'S REFERRAL INFORMATION**

Referred by: \_\_\_\_\_  
 Name (s) of other physician (s) who care for you: \_\_\_\_\_

**EMERGENCY CONTACT**

Name of person not living with you: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone number (home): ( ) \_\_\_\_\_ Phone number (work): ( ) \_\_\_\_\_

**ASSIGNMENT OF BENEFITS \* FINANCIAL AGREEMENT**

I hereby give lifetime authorization for payment of insurance benefits to be made directly to **Gastroenterology Specialties, P.C. or Lincoln Endoscopy Center, L.L.C** for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Date: \_\_\_\_\_ Your Signature: \_\_\_\_\_

**Method of Payment**

Cash \_\_\_ Check \_\_\_ Mastercard \_\_\_ Visa \_\_\_ Discover \_\_\_ American Express \_\_\_