Gastroenterology Specialties P.C. Lincoln Endoscopy Center, L.L.C.

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_____

Race: _____ Ethnicity: _____ Language: _____

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 ( )_____ Spouse's cellular phone ( )_____

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: _____

Home phone number ( )_____ Work or cell number ( )_____

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**: _____