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

DATE _____ ☐ NEW ☐ UPDATE

GENERAL PATIENT INFORMATION

PATIENT'S LAST NAME | FIRST NAME | MIDDLE

LOCAL ADDRESS | APT/LOT# | CITY | STATE | ZIP

PERMANENT ADDRESS (if Different than Local Address)

( )
PREFERRED CONTACT NUMBER
☐ Cell ☐ Home ☐ Work

SOCIAL SECURITY NUMBER | DATE OF BIRTH | ☐ MALE ☐ FEMALE

( )
ALTERNATE CONTACT NUMBER
☐ Cell ☐ Home ☐ Work

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

PREFERRED LANGUAGE: | ETHNICITY | EMAIL ADDRESS

EMPLOYER/NAME OF SCHOOL | SPOUSE'S NAME | ( ) SPOUSE CONTACT NUMBER

IN CASE OF EMERGENCY

NAME OF PERSON TO NOTIFY IN CASE OF EMERGENCY | RELATIONSHIP | CONTACT NUMBER

IF THE PATIENT IS A MINOR OR STUDENT

IF PATIENT IS A MINOR,WHO MAY AUTHORIZE TREATMENT | RELATIONSHIP | DATE OF BIRTH

IF PATIENT IS A MINOR,WHO IS THE RESPONSIBLE PARTY | RELATIONSHIP | DATE OF BIRTH

PERFERRED CONTACT NUMBER | ALTERNATE CONTACT NUMBER

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY NAME | EMPLOYER NAME IF INSURANCE IS THROUGH EMPLOYER

EFFECTIVE DATE | GROUP NUMBER | POLICY/ID NUMBER

INSURED'S NAME | INSURED'S DATE OF BIRTH | RELATIONSHIP TO ENSURED

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY NAME | EMPLOYER NAME IF INSURANCE IS THROUGH EMPLOYER

EFFECTIVE DATE | GROUP NUMBER | POLICY/ID NUMBER

INSURED'S NAME | INSURED'S DATE OF BIRTH | RELATIONSHIP TO ENSURED

ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENT

I HEREBY GIVE LIFETIME AUTHORIZATION FOR PAYMENT OF INSURANCE BENEFITS TO BE MADE DIRECTLY TO GASTROENTEROLOGY SPECIALTIES, P.C. OR LINCOLN ENDSOCOPY 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 HAVE BEEN MADE AWARE OF THE NOTICE OF PRIVACY PRACTICES. I FURTHER AGREE THAT A PHOTOCOPY OF THIS AGREEMENT SHALL BE AS VALID AS THE ORIGINAL.

PATIENT/PARENT/GUARDIAN SIGNATURE | DATE