❑ NEW PATIENT
❑ PROCEDURE
❑ UPDATE

# GASTROENTEROLOGY CENTER, PA
# PATIENT INFORMATION FORM

❑ HANS ADAMS, MD
❑ WARREN HIATT, MD
❑ PETER BERNHEIM, MD
❑ SCOTT GIOE, MD

DATE: _____

Have you ever seen the doctors before? _____

Under what name? _____

| PATIENT<br>☐ Single<br>☐ Married<br>☐ Separated<br>☐ Divorced<br>☐ Widowed<br>(check one)<br>☐ Male<br>☐ Female | Last Name | First Name | Middle | | Date of Birth |
|---|---|---|---|---|---|
| | Street Address | City | State | Zip | Age |
| | Mailing Address | City | State | Zip | Phone - Home |
| | Social Security Number | | | | Phone - Pts. Work |
| | Name of Employer/School | | | | Referred By |
| | Employer's Address | | | | Spouse's Name |
| Nearest Relative (not living with you) | | | | | Relationship |
| Address | | City | State | Zip | Phone |
| In Case of Emergency, Notify | | | | | Phone |

| RESPONSIBLE PARTY<br>☐ Self<br>☐ Spouse<br>☐ Parent<br>☐ Guardian<br>☐ Other<br>(check one) | Last Name | First Name | Middle | Social Security Number |
|---|---|---|---|---|
| | Billing Address | | | Date of Birth |
| | City, State, Zip | | | Phone - Home |
| | Employer | | | Phone - Work |
| | Employer's Address | | | |

**EVEN THOUGH INSURANCE COVERAGE IS LISTED, YOU ARE RESPONSIBLE FOR PAYMENT OF SERVICES.**

**METHOD OF PAYMENT**
☐ Cash ☐ Check ☐ Credit Card

| INSURANCE INFORMATION | Primary Insurance | | Secondary Insurance | |
|---|---|---|---|---|
| | Policy/Contract No. | Group No. | Policy/Contract No. | Group No. |
| | If Group, Name of Policy Holder (Employer, Union, Etc.) | | If Group, Name of Policy Holder (Employer, Union, Etc.) | |
| | Insured's I.D. or Social Security No. (If other than self) | | Insured's I.D. or Social Security No. (If other than self | |
| | SEND CLAIMS TO: | | SEND CLAIMS TO: | |
| RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS | **Insurance Authorization and Assignment**<br>I hereby authorize my insurance company to pay benefits directly to Drs. Adams, Hiatt, Bernheim, and/or Gioe. I authorize the release of information to the insurance company for my claims to be paid with above insurance information provided. I acknowledge I am responsible for payment of services rendered. | | | |
| Signature of Insured/Responsible Party | | | Date | |

Gastroenterology
CENTER

# NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I, _____, A PATIENT OF DR. _____ DO HEREBY ACKNOWLEDGE RECEIPT OF THE GASTROENTEROLOGY CENTER PA NOTICE OF PRIVACY PRACTICES IN ACCORDANCE WITH THE NEW HIPPA REGULATIONS. I REALIZE THAT IF I HAVE ANY QUESTIONS CONCERNING THESE PRIVACY PRACTICES, A MEMBER OF THE STAFF OR THE PRIVACY OFFICER, RHONDA PARKER, 863-8836, EXT. 421, WILL EXPLAIN THEM TO ME.

_____ _____

PATIENT SIGNATURE DATE