GASTROENTEROLOGY ASSOCIATES / ABILENE ENDOSCOPY CENTER

PATIENT INFORMATION

CHART #: ____________________

PLEASE PRINT & PRESS FIRMLY

DATE: ____________________

NAME: ____________________ DATE OF BIRTH: ____________ AGE: ______ SEX: ______

ADDRESS: ____________________ MARITAL STATUS: S M W D SEP

CITY & STATE: ____________________ ZIP CODE: ____________

HOME PHONE: ____________________ SOCIAL SECURITY #: ____________

OCCUPATION: ____________________

EMPLOYER: ____________________ PHONE #: ____________

ADDRESS: ____________________ CITY, STATE, ZIP: ____________

PARENT/SPOUSE NAME: ____________________ OCCUPATION: ____________

EMPLOYER: ____________________ PHONE #: ____________

ADDRESS: ____________________ CITY, STATE, ZIP: ____________

INSURANCE INFORMATION MEDICARE #: ____________ MEDICAID#: ____________

PRIMARY INSURANCE COMPANY: ____________________

POLICY HOLDER ID NUMBER: ____________________ GROUP #: ____________

DEPENDENT ID NUMBER: ____________________

MAILING ADDRESS: ____________________ PHONE #: ____________

____

SECONDARY INSURANCE COMPANY: ____________________

POLICY HOLDER ID NUMBER: ____________________ GROUP #: ____________

DEPENDENT ID NUMBER: ____________________

MAILING ADDRESS: ____________________ PHONE #: ____________

____

NEAREST RELATIVE NOT LIVING WITH YOU

NAME: ____________________ RELATIONSHIP: ____________

ADDRESS: ____________________ PHONE #: ____________

REFERRED BY: ____________________

To the best of my knowledge, the above information is correct and I hereby authorize this facility to release medical information to my insurance company/ Primary Physician

SIGNATURE: ____________________

FOR OFFICE USE ONLY

DATE SCHEDULED: ____________ DR.: 2 3 4 5 6

PROCEDURE: ____________ DATE: ____________ TIME: ____________

DIAGNOSIS: ____________________

PROCEDURE INSTRUCTIONS GIVEN BY: ____________ DATE: ____________ VERBAL☐ MAILED☐

PRE-PROCEDURE ANTIBIOTICS NECESSARY? Y N If yes, list antibiotics to be given: ____________

ALLERGIES: ____________________

PRE-CERTIFICATION NECESSARY: Y N PERSON TALKED TO FOR PRE-CERT: ____________

PRE-CERTIFICATION PHONE #: ____________ PRE-CERT REFERENCE #: ____________

VERIFICATION OF BENEFITS: DATE CALLED: ____________ TALKED WITH: ____________

	FACILITY	PHYSICIAN
OUT OF POCKET AMOUNT		
OUT OF POCKET MET		
AMOUNT OF DEDUCTIBLE		
AMOUNT OF DEDUCTIBLE MET		
AMOUNT OF DEDUCTIBLE NOT MET		
ALLOWABLE	%	
PERCENTAGE NOT PAYABLE (AMOUNT PATIENT PAYS)	%	

PAYMENT DUE AT THE TIME OF SERVICE

FACILITY ____________

PHYSICIAN ____________