MAIN GASTROENTEROLOGY, P.C.

PATIENT REGISTRATION

Today's Date:______________________ Date of Birth:______________

(Mr,Mrs.Ms.)
Name:______________________________ Soc.Sec:#_______________

Address:____

City, State, Zip:____

Home Phone #:________________Work Phone#:____________________

Cell Phone #:__________________E-Mail Address:__________________

Occupation/Employer:____

EMERGENCY CONTACT INFORMATION

Name:_____________________ Relation:__________ Phone#:_________

PHYSICIANS:

Primary Physician:________________________Phone#_______________

Referring Physician:_______________________Phone#_______________

PHARMACY NAME:____________________PHONE#______________

PRESCRIPTION DRUG PLAN_________________________________

INSURANCE AND BILLING INFORMATION:

PRIMARY INSURANCE_______________________________________

IDENTIFICATION #: _______________________GROUP#__________

Name of Insured:____________________Relation to Patient:____________

SECONDARY INSURANCE____

IDENTIFICATION#__________________________**GROUP#**__________

Name of Insured:______________________Relation to Patient:__________

IF YOUR INSURANCE REQUIRES A REFERRAL PLEASE MAKE SURE YOU GET THAT FROM YOUR PRIMARY PHYSICIAN BEFORE YOU COME TO OUR OFFICE OTHERWISE YOU WILL HAVE TO SIGN A WAIVER AND PAYMENT WILL BE YOUR RESPONSIBILITY.

PLEASE CALL THE OFFICE WITHIN 24 HOURS TO AVOID A LATE PAYMENT OF $25.00.

THANK YOU.