

MID-FLORIDA GASTROENTEROLOGY GROUP, P.A.
PATIENT REGISTRATION FORM

PATIENT NAME _____

DATE OF BIRTH _____ (CIRCLE ONE) MALE/FEMALE

MAILING ADDRESS _____

CITY/STATE _____ ZIP CODE _____

HOME # _____ WORK# _____

CELL# _____ SOCIAL SECURITY# _____

WHEN CONTACTING ME, PLEASE 1ST CALL MY (CIRCLE): HOME/WORK/CELL

PRIMARY CARE PHYSICIAN NAME _____

MARITAL STATUS: () SINGLE () MARRIED () DIVORCED () WIDOWED

EMERGENCY CONTACT _____ PH# _____

PATIENT'S EMPLOYER _____ PH# _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____

POLICY HOLDER _____ DATE OF BIRTH _____

SECONDARY INSURANCE _____

POLICY HOLDER _____ DATE OF BIRTH _____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. I HEREBY AUTHORIZE **MID-FLORIDA GASTROENTEROLOGY GROUP** TO APPLY FOR BENEFITS ON MY BEHALF FOR ALL COVERED SERVICES RENDERED BY THEM OR THEIR ORDERS. I REQUEST THAT PAYMENT FROM MY INSURANCE COMPANY BE MADE DIRECTLY TO **MID-FLORIDA GASTROENTEROLOGY GROUP**. I CERTIFY THAT THE INFORMATION I HAVE REPORTED WITH REGARD TO MY INSURANCE COVERAGE IS CORRECT. EITHER I OR MY INSURANCE COMPANY MAY REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING.

SIGNATURE _____ DATE _____

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