Patient Information

[To be completed by Patient/Parent/Guardian]

Today's Date____________________

Patient Name ___________________________ ___________________________ _____ **Date of Birth** _____/_____/_____
Last Name First Name M.I.
Maiden/Previous name(s) *(if applicable)*____ **Daytime Phone #:** _____________
Street Address __________________________________ **Mailing Address** __________________________________
City _____________________ **State** _____ **Zip** ________ **Home Phone**_____________ **Work Phone**______________
Soc. Sec# ____________________________ *Please Circle* **(E)mployed (P)art-time Student (F)ull-time Student Employers**
Name __________________________________ **School Name** _________________________________
Next of Kin ___________________________ **Phone** _____________ **Relationship**____________________________
Primary Care Physician _______________________________**Office location:** ______________________________
Is visit related to: ☐**Employment** ☐**Auto Accident—***if yes*, **State**____ ☐**Other Accident—*date of injury***_______
Have you ever had a Colonoscopy or Upper Endoscopy before? ☐No ☐Yes—*if yes, what, where, when?* ______________
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Insurance Information: *(Copies of all your insurance cards are required)*

Primary Insurance *Effective Date of Policy:*____________________
Insurance Company ____ Subscriber's Employer______________________
Subscriber Name ______________________________ Date of Birth________ Relationship: (S)elf (W)ife (H)usband (C)hild

Secondary Insurance *Effective Date of Policy:* __________________
Insurance Company ____ Subscriber's Employer_____________________
Subscriber Name ______________________________ Date of Birth________ Relationship: (S)elf (W)ife (H)usband (C)hild

The physicians/staff of Atlantic Digestive Specialists has my permission to discuss my medical condition and/or history with:
******You must notify us if you wish to change your permission form****** ***(Check all boxes that apply)***

Leave message at my home with: Name:____________________________________ Relationship:__________________
and Name:____________________________________ Relationship:__________________
and Name:____________________________________ Relationship:__________________

Atlantic Digestive Specialists has my permission to: (check if applicable)

☐ Leave message on cell phone.	***Cell** phone number*	( )_________________________
☐ Leave message at work.	***Work** phone number*	( )_________________________
☐ Leave a message on voicemail.	***Other** Phone number*	( )_________________________
☐ Leave a message on answering machine:	***Other** Phone number*	( )_________________________

For All Insurances

I authorize payment of my insurance medical benefits and the release of any medical or other information necessary to process my claim(s) to Atlantic Digestive Specialists for all services rendered.
Patient /Guardian Signature ____Date______________________

Medicare Only Patients

How are you eligible for Medicare? ☐AGE ☐DISABILITY ☐OTHER Are you still employed? ☐YES ☐NO
Is your spouse still employed? ☐YES ☐NO Are you still eligible for an employment group health plan? ☐YES ☐NO
If yes, Name and Address of Employer's Health Plan: ____

Authorization to Submit Charges to Medicare

I request, until further notice that payment of authorized Medicare benefits be made on my behalf to Atlantic Digestive Specialists for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration or its agents any information needed to determine these benefits or the benefits payable for related services. The above authorization may also be used for billing any Medigap/other insurance.

Patient Signature ____ Date ______________________ Form 697A