

Southeast Valley Gastroenterology Consultants
Demographic Information Form

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Name: _____			Date of Birth: _____		
Last	First	Mi.	Gender: M or F Age: _____		
Address: _____			Marital Status: S M D W		
Street					
City	State	Zip	Social Security # _____		
Email address: _____					
Preferred language: _____		Race: _____		Ethnicity: _____	
Telephone: Home: () _____ Work: () _____ Cell: () _____					
Employer: _____			Occupation: _____		
Name					
Street	City	State	Zip		

Primary Care Doctor: _____ Primary Care Doctor's Phone #: _____

Referring Provider: _____ Pharmacy Phone #: _____

Emergency Contact Person (s):

Name: _____ Phone: _____ Relationship to Patient: _____

Do we have your permission to discuss your case with certain specified relatives and/or friends of your choosing?

YES NO Name/Relationship: _____

Do we have your permission to leave messages on your answering machine at home or voicemail at work? YES NO

Insurance Information:

Insurance Plan: _____ ID #: _____

Policy Owner: _____ SS#: _____ D.O.B: _____

Employer of Policy Owner: _____ Phone: _____

Address: _____

Street	City	State	Zip
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Secondary Insurance: _____ ID#: _____

Policy Owner: _____ SS#: _____ D.O.B: _____

I understand that I am responsible for all charges regardless of insurance coverage. I agree to pay my account with this office in accordance with the regular rates and payment terms of this office.

In the event I am entitled to health insurance or other benefits relating to my medical condition and they are available to cover the costs of treatment provided by this office, I hereby assign those benefits to this office to be applied to my bill. The office may release record of my treatment to my insurance company or other third parties responsible for payment of my medical charges.

Patient Signature: _____ **Date:** _____