Advanced
Gastroenterology of Texas

2698 N GALLOWAY
Suite 103
Mesquite, TX 75150
Phone (214) 962-4863
Fax (214) 758-1400
www.advancedgastrodoc.com

9 MEDICAL PARKWAY
PLAZA 4 SUITE 206
DALLAS, TX 75234

PATIENT REGISTRATION FORM

Today's Date _____ Primary Care Physician_____

Patient Information-*Please print. Enter name as it's shown on your insurance card.*

Patient Name (Last)_____(First)_____(MI)_____

Date of Birth_____ Age _____ ❒ Male ❒ Female Marital Status ❒ S ❒M ❒ D ❒W

Social Security Number_____ Driver's License Number_____

Address_____(City)_____

(State)_____(Zip)_____(Email)_____

Home Phone_____Cell_____Preferred Method of Contact ❒ Home ❒ Cell

Employer_____(Address)_____

(City)_____(St)_____(Zip)_____(Work Phone)_____

If Patient is Under 18-Guarantor Name_____(Phone)_____

Insurance Information

Primary Insurance_____Insured Name_____

Insured Date of Birth_____ Relationship to Patient ❒ Spouse ❒ Parent ❒ Other_____

Policy ID Number _____ Group Number _____

Ins Phone_____Ins Address_____

Secondary Insurance_____Insured Name_____

Insured Date of Birth_____ Relationship to Patient ❒ Spouse ❒ Parent ❒ Other_____

Policy ID Number _____ Group Number _____

Ins Phone_____Ins Address_____

I hereby assign all medical and/or surgical benefits, to include major medical to which I am entitled, including Medicare, and other government sponsored programs, private insurance and any other health plan to Advanced Gastroenterology of Texas, PLLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize Advanced Gastroenterology of Texas PLLC to release all information to secure the payment.

_____ _____

Signature of Patient or Legal Guardian Date