Advanced Gastroenterology of Texas

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PATIENT REGISTRATION FORM

Today Date ________________ Primary Care Physician ________________________

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

Name (Last) ______________________________ First ________________________________ MI_________

Date of Birth__________________ Age ______ Sex: _______________Marital Status: _________________

Social Security Number: ________________________ Driver's License _____________________________

Address ____City______________________________

State _______ Zip ____________ Email: ______________________________________

Home Phone ___________________ Cell Phone _________________ Work _________________

Preferred Method of Contact: ________________

May We leave a detailed message on your answering machine or voicemail? ____________

Employer _____________________________________ Address ________________________________

City __________________ State ________ Zip___________ Work Phone ________________

Insurance Information

Primary Insurance __________________________________ Insured Name ___________________________

Insured Date of Birth ____________________ Relationship to patient _____________________

Policy ID Number __________________________ Group Number _______________________

Ins Phone ________________________ Ins Address ____

Secondary Insurance __________________________________ Insured Name __________________________

Insured Date of Birth ____________________ Relationship to patient _____________________

Policy ID Number __________________________ Group Number ________________________

Ins Phone _______________________ Ins Address ____

I hereby assign all medical and/or surgical benefits, to include major or 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.

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Signature of patient or Legal Guardian