PLEASE PRINT CLEARLY

GastroIntestinal Specialists A.M.C.

Patient Name	SSN	Date of Birth	Age	Gender ❑ Female ❑ Male
Mailing/Street Address		City, State, Zip Code		

Race ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Greek ❑ Hispanic ❑ Indian ❑ Multi-Racial ❑ Native Hawaiian or other Pacific Islander ❑ White	Ethnicity ❑ Hispanic ❑ Non-Hispanic

Marital Status ❑ Divorced ❑Married ❑ Single ❑Separated ❑Widowed	Primary Care Physician	Referring Physician

Home Phone Number ( )	Day Phone Number ( )	Cell Phone Number ( )	Email Address

Patient's Employer Name	Employer Address	City, State, Zip Code

Spouse or Parent's Name	Home Phone Number ( )	Street Address	City, State, Zip Code
Spouse or Parent's Employer	Business Phone Number ( )	Emergency Contact	Phone Number ( )

IMPORTANT! PLEASE READ CAREFULLY.
INSURANCE AUTHORIZATION AND ASSIGNMENT AND/OR MEDICAL RELEASE.

I hereby authorize GastroIntestinal Specialists, A.M.C. to furnish any information or to obtain any information from any insurance carrier, physician, attorney, employer, hospital, other health care provider, Louisiana Research Center, or any affiliated entity concerning my medical history, illness and treatments. I hereby assign GastroIntestinal Specialists, A.M.C. all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Date _____ **Signature** _____

Name of Primary Insurance Company		Effective Date of Policy
Insurance Company's Address, City, State, Zip Code		Phone Number ( )
Insured's Name	Insured Date of Birth	SSN
Policy Number	Contract Number	Group Number
Name of Secondary Insurance Company		Effective Date of Policy
Insurance Company's Address, City, State, Zip Code		Phone Number ( )
Insured's Name	Insured Date of Birth	SSN
Policy Number	Contract Number	Group Number