WACO GASTROENTEROLOGY ASSOCIATES PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: _____

Date of Birth: _____ / _____ / _____ SSN: _____ - _____ - _____ Sex: Male - Female

Home Address: _____ City: _____ State: _____ Zip: _____

Mailing address (if different): _____ City: _____ State: _____ Zip: _____

Primary Phone Number: _____ Type: home - cell - work

Secondary Phone Number: _____ Type: home - cell - work

Other Phone Number: _____ Type: home - cell - work

Can we send text message(s) to your cell phone for appointment reminders? Yes - No

Email address: _____ Preferred contact: phone - mail - email

Contact person not living with you: _____ Phone: _____

Employer: _____ Employer Address: _____

Race: _____ Ethnicity: Hispanic - NonHispanic Preferred Language: _____

Primary Care/Family Physician: _____ Phone: _____

Preferred Pharmacy: _____ Location: _____

Primary Insurance: _____ Policy holder: _____

If policy holder other than self, relationship: _____, DOB: _____ SSN: _____

Secondary Insurance: _____ Policy holder: _____

If policy holder other than self, relationship: _____, DOB: _____ SSN: _____

Please provide your insurance card(s) so we may make a copy for complete information.

Person(s) to whom WGA may disclose my Personal Health Information: _____

_____

I hereby assign, transfer, and set over to Waco Gastroenterology Associates, PA (WGA) all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization will remain valid until I revoke it in writing. I understand that I am finically responsible for all charges whether or not they are covered by insurance. I request and give my consent to WGA to provide and perform such medical services as are considered necessary or beneficial by my healthcare provider for my health and well-being. I acknowledge WGA makes no representations, warranties or guarantees as to the results or cures. WGA has made available to me a copy of its Notice of Privacy Practices, Patient Rights and Responsibilities and Patient Financial Policy and I agree to abide by such policies. A photocopy or facsimile copy of this document is a valid as the original.

_____ _____

Patient or Legally Authorized representative signature *Date*

_____

Relationship to patient

Verified by staff: _____ initial date _____

Revised 5-14-2015