



DATE:

LAST NAME		FIRST		MIDDLE INITIAL		DATE OF BIRTH	AGE
SOCIAL SECURITY NUMBER		SEX: M F	MARITAL STATUS S M W Div Sep		PRIMARY CARE PHYSICIAN		
LOCAL ADDRESS		STREET	CITY		ZIP	HOME PHONE () -	
ALTERNATE ADDRESS		STREET	CITY		ZIP	CELL PHONE () -	
EMPLOYER						WORK PHONE () -	
OCCUPATION (even if retired)			HOW LONG	RETIRED YES NO	DISABLED YES NO	BEST DAYTIME # HOME CELL WORK	
SPOUSE or PARENT'S INFORMATION:							
NAME			ADDRESS				
RELATIONSHIP	HOME PHONE () -		EMPLOYER			WORK PHONE () -	
PERSON RESPONSIBLE FOR PAYMENT:							
NAME			ADDRESS			PHONE	
INSURANCE CARRIERS: <i>Please complete this section and present card to receptionist</i>							

Primary Insurance

Carrier Name _____ ID # _____ Grp # _____

Name of Policy Holder: _____ Date of Birth _____ SS# _____
(As it appears on your card)

Secondary Insurance

Carrier Name _____ ID # _____ Grp # _____

Name of Policy Holder: _____ Date of Birth _____ SS# _____
(As it appears on your card)

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS:

I hereby acknowledge Gastroenterology Associates of Ithaca, P.C.'s (the practice) right to furnish information to insurance carriers concerning my medical condition and treatment. I hereby assign the practice all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. I also accept responsibility for fees that exceed the payment made by my insurance, if the practice does not participate with my insurance. I understand I am responsible for all fees and finance charges.

All Patient's Signature:	Date:
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MEDICARE ASSIGNMENT: (Medicare Patients Only)

I request that payment of authorized Medicare and Medigap benefits be made either to me or on my behalf to Gastroenterology Associates of Ithaca P.C. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Medicare Patient's Signature:	Date:
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