Bay Area Gastroenterology

Board Certified * Gastroenterology * Internal Medicine * Clinical Faculty

PATIENT DEMOGRAPHICS

Name_____Date of Birth_____Age____Sex_____
Social Security#___-____-____ Driver License#_____State_____
Address_____State____Zip_____Home#_____Cell_____

Employed by:_____Occupation_____Business#_____
Address:_____City_____State____Zip_____

Marital Status: Single Married Divorced Widowed Email Address:_____

Spouse's Name_____Social Security#____-____-_____
Employed by:_____Date of Birth_____

Person To Notify in Case of Emergency:_____Phone #_____
_____

Primary Insurance_____Insured ID #_____
Address:_____Phone#_____
Insured's Name_____Patient Name_____
Patient's Relationship to Insured: Self Spouse Child Other **Spouse's DOB_____

Secondary Insurance_____Insured ID#_____
Insurance address_____City_____State_____Zip_____
Insurance Phone #_____Insured's Name_____

I agree that I am responsible for all services rendered as a patient and that payment is due and payable to Bay Area Gastroenterology, PA . I agree to pay all deductibles and co-pays at the time of Service. (if I have dual insurance coverage, my co-pay or deductible will be based on the primary coverage). I understand that while Bay Area Gastroenterology, PA will file claims with my insurance on my behalf, I remain responsible to Bay Area Gastroenterolgy,PA for what is not paid by my Insurance. I Also understand that if Bay Area Gastroenterolgy, PA cannot verify insurance Benefits eligibility for me prior to visit that I will pay in full for the services at the time they are rendered. I understand Bay Area Gastroenterology, PA, may charge; 1) an amount equal to $25.00, but not to exceed the maximum amount permitted by law for each returned check.. I agree to the extent permitted by law, that if my account balance is referred to any agency or attorney(s) for collection purposes to pay reasonable attorney's fees and any expenses or costs relating to the collection proceeding, including court costs.

Signature of Responsible Party:_____Date_____