AGIS Alexandria GastroIntestinal Specialists

Patient Demographic Information

Account #:

Patient Name: _____

Age: _____ Date of Birth: _____ Gender: _____ SSN: _____

Address: _____ Unit/Suite/Apt#: _____

City, State, Zip: _____ Email Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer Name: _____ Employer Phone: _____

Emergency Contact Name (NOT LIVING WITH YOU): _____

Emergency Contact Phone:_____ Relationship to Patient:_____

Guarantor/Spouse Name: _____ Date of Birth: _____

Guarantor/Spouse SSN: _____ Phone: _____

Insurance Information

Primary: _____ Policy/Member ID: _____ Group:_____

Policy Holder Name: _____ Policy Holder DOB: _____/_____/_____ Sex: Male / Female

Policy Holder SSN: _____ Relationship to Patient: _____

Secondary: _____ Policy/Member ID: _____ Group: _____

Policy Holder Name: _____ Policy Holder DOB: _____/_____/_____ Sex: Male / Female

Policy Holder SSN: _____ Relationship to Patient: _____

Primary Care & Referring Physician Information

Are your primary care physician and referring physician the same? Yes ◯ No ◯

Primary Physician: _____ Primary Physician Phone: _____

Referring Physician: _____ Referring Physician Phone: _____

Authorization for Voicemail regarding Health Information

I hereby give permission to leave message(s) on my voicemail concerning my personal health information. Initials: _____
I further understand that this permission to communicate my personal health information will remain in effect until I request, in writing, to have this option of communication terminated.

Assignment & Authorization of Benefits

I hereby give authorization for payment of insurance benefits to be made directly to Alexandria GastroIntestinal Specialists for services rendered. I understand that I am financially responsible for all charges whether they are covered by insurance. In the event of default, I agree to pay all costs of collection and responsible attorney fees. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement is as valid as the original.
AGIS frequently utilizes mid-level practitioners including Advanced Practice Nurses to assist in the delivery of medical care. Mid-level practitioners are under the supervision of a physician and can diagnose, treat, and monitor common acute and chronic diseases. I hereby consent to the services of a mid-level practitioner for my health care needs. I understand that at any time I can refuse to see the mid-level practitioner and request to see a physician.

_____ _____

Signature of Patient of Legal Representative **Date**