California Advanced Gastroenterology

Patient Registration Record

Name: _____ ____ _____
first mi last

Address: _____

City: _____ **State**: _____ **Zip code**: _____

Telephone: home (_____)_____ work (_____) _____

Date of Birth: _____**Age**: _____ **Social Security #**: _____

Employer: _____

Spouse's Name: _____ **Spouse's Soc Sec#**: _____

Spouse's Employer: _____

Primary Care Physician: _____

Emergency Contact: _____ _____
name telephone #

Insurance Information

PRIMARY INSURANCE

Insurance Co_____

ID or Policy #_____

Group #_____

Insured's Name
(if different)_____

SECONDARY INSURANCE

Insurance Co_____

ID or Policy#_____

Group # _____

Insured's Name
(if different)_____

Payment for Service: I understand that I am financially responsible for all charges incurred for services rendered.. I hereby assign payment of all insurance benefits to California Advanced Gastroenterology and/or David J. Schneiderman, M.D.

Authorization to Release Medical Information: I authorize the release of my medical records by mail, fax or telephone to the physician or physicians to whom I may be referred. I authorize the release of any medical information necessary to process insurance claims.

_____ _____
Signature Date