Gastroenterology Associates: New Patient Registration Form Gastro MD: _____

A. Patient Information

Name *(First, M.I., Last)*: _____ Sex: M / F

Address: _____
Street *City* *State* *Zip Code*

Phone - Daytime: _____ Eve: _____ Cell: _____

Social Security #: _____ Birthdate: _____

Emergency contact *(name, relationship, phone)*: _____

B. Physician Information

Primary care physician (*PCP*): _____ City, State: _____

Referring MD *(only if not PCP)*: _____ City, State: _____

C. Insurance Information

Insurance company *(circle)*:

Blue Cross RI	Aetna	Neighborhood Health Plan
Blue Cross MA	Cigna	Tufts
Blue Cross Federal	Harvard Pilgrim	United Health Care
Blue Chip Commercial	Medicaid	UHC Senior Care
Blue Chip Medicare	Medicare	Other: _____

*Note: If you have more than one insurance, please mark primary coverage with a **

Primary insurance

Patient ID #: _____ Group ID # *(Aetna & UHC only)*: _____

Policyholder name and birthdate *(only if not patient)*: _____

Secondary insurance

Patient ID #: _____ Group ID # *(Aetna & UHC only)*: _____

Policyholder name and birthdate *(only if not patient)*: _____

D. Release of Medical Information

I hereby authorize the release of medical information as required in filing claims with my insurance company.

Signature: _____ Date: _____

E. Financial Responsibility

I hereby accept financial responsibility for payment of any copays, coinsurance, deductibles, or other uninsured fees.

Guarantor (*only if not patient*):_____

Signature: _____ Date: _____