Capital City Gastroenterology, P.C.
4126 Carmichael Court
Montgomery, AL 36106
Phone: (334)495-2600 Fax: (334)495-2604

Patient Information

Last Name________________________________ First Name_________________________ MI_______

Sex: M F (circle one) Date of Birth:______________________________ Marital Status: S M W D (circle one)

Social Security Number ___________________________ Driver License #________________________

Email Address____

Address____

City ________________________________ State_____________ Zip_____________________________

Home Phone (___)___________________ Cell (___)___________________Work (___)________________

Primary Physician_________________________________ Referring Physician______________________

Occupation______________________________________ Employer______________________________

Emergency Contact________________________________ Relationship___________________________

Home Phone (___)___________________ Cell (___)___________________Work (___)________________

Insurance Information

Primary Insurance Company____

Policy Number_______________________________ Group Number _____________________________

Policy Holder Name___________________________________ Relation to Patient ___________________
(if other than patient)

Policy Holder Employer_______________________________ Policy Holder Birthday________________

Policy Holder Social Security Number____

Secondary Insurance Company____

Policy Number_______________________________ Group Number _____________________________

Policy Holder Name___________________________________ Relation to Patient ___________________
(if other than patient)

Policy Holder Employer_____________________________Birthday______________ SS#_______________

Please provide a copy of front and back of all insurance cards.

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Please complete and sign this form in all places

I hereby authorize Capital City Gastroenterology, P.C. to make claims to may assigned insurance benefits. I understand the payment of charges or fees is my responsibility. I agree to pay all collection and attorney fees associated with the collection of my account.

____________________________ ______________________________ ____________
Print Name Signature Date

I hereby authorize the release of all medical information to my insurance companies as is necessary to file claims on my behalf in accordance with HIPAA rules. (See HIPAA NPP advice)

____________________________ ______________________________ ____________
Print Name Signature Date

I hereby assign insurance benefits payments to Capital City Gastroenterology, P.C. for all inpatient and outpatient procedures, office visits and services provided to me by Capital City Gastroenterology, P.C.
I understand that I may be charged a no-show/cancellation fee of $100.00 if I fail to keep a scheduled procedure, or if I fail to cancel within 48 hours of the procedure, except in the case of a verifiable emergency.

____________________________ ______________________________ ____________
Print Name Signature Date

May your lab results or procedure/office visit information be given to anyone other than yourself? Yes No

If yes, who whom?

Name____ Relationship____________________

Name____ Relationship____________________

Name____ Relationship____________________

May we leave your lab results or appointment information on your answering machine? Yes No

May we send appointment or general information to your email address? Yes No

Please sign and date to authorize release of information as described above.

____________________________ ______________________________ ____________
Print Name Signature Date