Johns Creek Gastroenterology

Clive Albert MD AGAF
Arumugam Natesan MD

PATIENT INFORMATION

PLEASE PRINT CLEARLY DATE:

Name:

First Middle Maiden Last

Address:

City State Zip Code

Home Phone # ( ) Work Phone # (_____)_____

Date of Birth:_____ Sex: M F Marital Status: S M D W

SSN: _____ Employer:

Employer's Address:

Responsible Party:

Spouse's Name: Work Phone #: (____)_____

Spouse's Date of Birth: Spouse's SSN:

Spouse's Employer:

Emergency Contact:

INSURANCE INFORMATION

Primary Insurance: Insured's Name:_____

Ins. Co. Address:

ID # _____ Group:_____ PCP:_____

Policy Type: (Circle) HMO PPO EPO CO-PAY:

Secondary Insurance: Insured's Name:_____

Ins. Co. Address:

ID# _____ Group: _____ PCP:_____

REFERRED BY DOCTOR:_____ PHONE NO: (____)_____

THE FOLLOWING AUTHORIZATIONS MUST BE SIGNED BY THE PATIENT OR GUARDIAN BEFORE ANY INSURANCE FORMS OR MEDICAL REPORTS CAN BE RELEASED FROM THIS OFFICE

I authorize Johns Creek Gastroenterology PC to disclose complete information to my insurance company or physician having just cause to such information concerning the medical findings and treatment, including copies of records. I also understand that it is my responsibility to obtain referral or authorizations from my PCP if indicated by my insurance company.

Patient's Signature Date

I hereby authorize payment directly to Johns Creek Gastroenterology PC of surgical or medical benefits payable under the provisions of my policy. I understand that I am financially responsible for any amount not covered by my insurance.

_____

Patient's Signature Date

As a courtesy, we will file your insurance claims on your behalf.