PATIENT DATA DATE: _____

QUEEN CITY GASTROENTEROLOGY & HEPATOLOGY, PC

Patient's Full Name: _____
LAST FIRST MIDDLE

_____
Home Address City State Zip

_____ _____
Home Phone Office Phone

_____ Marital Status: Single Married
Birthdate Age Sex Separated Divorced Widowed

_____
Patient's Occupation Employed by Address

_____
Spouse's Name Birthdate

_____
Spouse's Occupation Employed by Address

_____
Responsible Party (Person financially responsible for bill) Address Phone #

INSURANCE INFORMATION (Please enclose copy of insurance/Medicare card – Front and Back)

Medicare #: _____ Name on Medicare Card: _____

_____
Certificate or Policy Number Group Number

_____
Insurance Co. Name Insured's Name

_____
Address claims should be mailed to

_____
Certificate or Policy Number Group Number

_____
Insurance Co. Name Insured's Name

_____
Address claims should be mailed to

This is to authorize Queen City Gastroenterology & Hepatology, PC to release any medical information necessary to process my claims with Medicare and/or Insurance. I also request payment of benefits to myself or to the party who accepts assignment.

Signature_____

Nearest relative not living with you:

_____
Name Address Home Phone Work Phone