

GASTROENTEROLOGY CLINIC OF SAN ANTONIO

8550 Datapoint Dr., Ste. 200 San Antonio, Tx. 78229

Telephone (210) 615-8308 Fax (210) 615-8313

PATIENT INFORMATION & AGREEMENT

Name _____ Date _____

Date of Birth _____ M ___ F ___ SS# _____

Address _____

City _____ Zip Code _____

Home Phone (____) _____ Cell# _____

Email: _____ Method of Contact: Cell _____ Email _____

Occupation _____

Spouse's Name _____

Primary Care Physician _____ Phone# _____

Referred by Dr. _____ Phone# _____

Insurance Carrier _____ ID# _____

Secondary Carrier _____ ID# _____

Emergency Contact: _____ Phone# _____

Assignment of benefits: I hereby assign all medical and or surgical benefits, to which I am entitled, including Medicare, Medicaid and private medical insurances and other health plan to Gastroenterology Clinic of San Antonio. This assignment will remain in effect until revoked by me in writing. Photocopy of this agreement is as valid as the original. I authorize assignee to release all information necessary to secure payment. I understand that I am financially responsible for all charges whether or not paid by said insurance. I authorize the release of any medical information to any physician (PCP referring) and /or insurance company as it relates to my continuation of care.

Patient's Signature _____ Date _____