GASTROENTEROLOGY CLINIC OF SAN ANTONIO, P.A.

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: _____

Preferred Method of Contact: Text_____ Cell _____Email_____

Occupation _____

Primary Care Physician _____Phone# _____

Referred by Dr. _____Phone# _____

Insurance Carrier_____ID#_____

Name of Insured_____ Dob_____

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 GCSA. 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. I hereby consent to the use of my contact information and email for the purposes of receiving health related material from my physician's office.

Patient's Signature_____ Date _____