

ACCOUNT # _____

DR. CODE _____

DATE _____

Gastro One

Orin L. Davidson, III, M.D.
Michael S. Dragutsky, M.D.
Raif W. Elsakar, M.D.
Daniel E. Griffin, M.D.
Christopher M. Griffith, M.D.
William G. Hardin, M.D.
Rolando J. Leal, M.D.

Randolph M. McCloy, M.D.
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Mary Portis Hall, M.D.
Anca I. Pop, M.D.
Geza Remak, M.D.
James H Rutland, III, M.D.
Alan D. Samuels, M.D.

David D. Sloas, M.D.
Charles R. Surles, Jr. M.D.
W. Zachary Taylor, M.D.
John D. Ward, M.D.
Robert S. Wooten, M.D.
Ziad H. Younes, M.D.
Chantil D. Jeffreys, R.N., F.N.P.

GUARANTOR INFORMATION

GUARANTOR

NAME: (first) _____ (middle initial) _____ (last) _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE : (_____) _____ - _____ SPOUSE NAME: _____

GUARANTOR SOCIAL SECURITY #: _____

PATIENT INFORMATION

PATIENT

NAME: (first) _____ (middle initial) _____ (last) _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE:(_____) _____ - _____ CELLULAR PHONE:(_____) _____ - _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

EMERGENCY PHONE:(_____) _____ - _____

PATIENT

BIRTH DATE: _____ / _____ / _____ SEX: _____ MARITAL STATUS: _____

SOCIAL SECURITY #: _____ RACE: _____

EMPLOYER NAME: _____

EMPLOYER ADDRESS: _____

EMPLOYER CITY: _____ STATE: _____ ZIP CODE: _____ COUNTY: _____

EMPLOYER PHONE:(_____) _____ - _____ EXT: _____

PRIMARY INSURANCE INFORMATION

CHARGES FOR ALL SERVICES ARE THE RESPONSIBILITY OF THE PATIENT/GUARANTOR. PLEASE BE INFORMED THAT WE LOOK TO YOU FOR PAYMENT IF YOUR INSURANCE COMPANY DOES NOT PAY YOUR CLAIM.

PRIMARY INSURANCE

INSURANCE COMPANY NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

GROUP #: _____ POLICY #: _____ CO PAY: _____

PATIENT RELATIONSHIP TO POLICYHOLDER: _____

PRIMARY INSURANCE POLICYHOLDER INFORMATION

POLICYHOLDER

NAME: (first) _____ (middle initial) _____ (last) _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE : (_____) _____ - _____ BIRTH DATE: ____ / ____ / ____ SEX: _____

SOCIAL SECURITY#: _____ POLICYHOLDER EMPLOYER PHONE:(____) _____ EXT: _____

POLICYHOLDER EMPLOYER NAME: _____

POLICYHOLDER EMPLOYER ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

GROUP #: _____ POLICY #: _____ CO PAY: _____

SECONDARY INSURANCE POLICYHOLDER INFORMATION

POLICYHOLDER

NAME:(first) _____ (middle initial) _____ (last) _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE : (_____) _____ - _____ BIRTH DATE: ____ / ____ / ____ SEX: _____

SOCIAL SECURITY# _____ - ____ - _____ POLICYHOLDER EMPLOYER PHONE:(____) _____ EXT: _____

POLICYHOLDER
EMPLOYER: _____

POLICYHOLDER EMPLOYER ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PATIENT RELATIONSHIP TO POLICYHOLDER: _____