Please fill out **COMPLETELY**, and bring with you for your appointment.
DO NOT MAIL!!

Gastroenterology Associates, Inc.
Gastroenterology Endoscopy Center
www.gastro-ohio.com

UPDATE YEARLY

PATIENT INFORMATION

USE INK ONLY.

Date: ______________

Patient: ____

Address: ____

City: ____________________ State: __________ Zip Code: __________

Home Phone No.: ( ) ______-______ Referred by: ____________________

Cell Phone No.: ( ) ______-______

Social Security No.: ____-____-____ Sex *(please circle)*: M F Race: __________

Date of Birth: ______________ Marital Status *(please circle)*: Married Widowed Divorced Single

---

Patient's Employer: ____

Is it OK to contact you at your employment? ☐ yes ☐ no Business Phone No.: ( ) ______-______

Spouse's Full Name: ____________________ Date of Birth: ______________

Primary Insurance: ____
(name of insurance co.) *(address)*

Contract No./I.D. Number ______________ Group No.: __________ Copay: __________

Policy Holder: ______________ Relationship: __________ DOB: __________

Secondary Insurance: ____
(address)

Contract No./I.D. Number ______________ Group No.: __________

Policy Holder: ______________ Relationship: __________

Family Physician: ____

Emergency Contact:

Name: ____________________ Phone No.: ( ) ______-______

If you would like to receive an invitation to join our secure patient portal, please provide your email address:

____

Please See Other Side

Gastroenterology Associates, Inc.
Gastroenterology Endoscopy Center

4665 Belpar St., N.W. • P.O. Box 36329 • Canton, Ohio 44735
(330) 493-1480

PLEASE SIGN WHERE MARKED!!!

MEDICARE PATIENTS: Please sign statement below:

I request that payment of authorized Medicare benefits be made on my behalf to Gastroenterology Assoc./Gastroenterology Endoscopy Center, Inc. for any services furnished me by one of the physicians. I authorize release to the Health Care Financing Administration and its agents any medical information about me needed to determine these benefits or benefits payable for related services.

X ______________________________ X ______________

PATIENT SIGNATURE DATE

NON-MEDICARE PATIENTS: Please sign statement below:

I UNDERSTAND THAT I AM RESPONSIBLE FOR FULL PAYMENT OF BY BILL, IN A TIMELY MANNER.

I authorize the release of any medical information necessary to process this claim:

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and other health plans to Gastroenterology Assoc., Inc./Gastroenterology Endoscopy Center.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

X ______________________________ X ______________

PATIENT/RESPONSIBLE PARTY SIGNATURE DATE