Bedford
GASTROENTEROLOGY

PATIENT INFORMATION

To assist us in updating your file and processing your insurance claim, please provide the following information. We must have complete and accurate information or your insurance provider may deny or delay processing your claim. **Please have your insurance card and picture ID with you at the time of service.**

Name: _____ _____ _____ _____
Last First Middle Initial Title: (Mr. Mrs. Ms.)

Address: _____ _____ _____ _____
Street City State Zip Code

Date of Birth: _____ Sex: _____ Social Security: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-Mail:_____

Emergency Contact Person:_____ Relationship:_____

Emergency Phone Number:_____

Race/Ethnicity (Circle One): American Indian Asian Black/African White Hispanic Other Decline

Preferred Language (Circle One): English Spanish Other Decline

Primary Care Physician:_____

I acknowledge receiving the Notice of Patient Privacy Practices (HIPPA) from Bedford Gastroenterology.

As a courtesy to our patients, we submit insurance claims to the Insurance Co., but we must collect copays at the time of service. I understand that it is my responsibility to provide a referral from my Primary Care Provider.

I authorize the release of any medical information necessary to process this claim. I also authorize payment of medical benefits directly to my care provider.

Signed: _____ Date:_____

*** **PLEASE NOTE: OUR OFFICE WILL CHARGE A $100 FEE FOR NO SHOW/CANCELLATION/RESCHEDULES MADE WITHIN 72 HOURS OF PROCEDURE DATE AND A $50 FEE FOR OFFICE VISITS.**

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