# New Patient Form

Patient Registration

Hattiesburg GI Associates
powered by GI Alliance

## PATIENT INFORMATION

REFERRING PHYSICIAN:_____

PRIMARY CARE PHYSICIAN:_____

PATIENT NAME:_____
LAST FIRST MIDDLE

DATE OF BIRTH:___/___/_____ GENDER:_____ EMAIL ADDRESS:_____

SOCIAL SECURITY #:_____

HOME PHONE:_____ CELL PHONE:_____ WORK PHONE:_____

HOME ADDRESS:_____

## PATIENT SPOUSE INFORMATION

SPOUSE NAME:_____ DATE OF BIRTH:___/___/___

GENDER:_____ PHONE:_____

## EMERGENCY INFORMATION

NAME OF SOMEONE NOT LIVNG WITH YOU:_____ PHONE:_____

ADDRESS:_____ RELATIONSHIP:_____

## INSURANCE INFORMATION

| | | | |
|---|---|---|---|
| PRIMARY | ID# | GROUP# | SUBSCRIBER'S NAME |
| SECONDARY | ID# | GROUP# | SUBSCRIBER'S NAME |
| TERIARY | ID# | GROUP# | SUBSCRIBER'S NAME |

**I AM RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED TO ME BY THIS CLINIC. (IF THE PATIENT IS UNDER 18, THE PARENT/GUARDIAN REQUESTING TREATMENT ASSUMES RESPONSIBILITY OF ALL CHARGES) FULL PAYMENT IS DUE AT THE TIME OF SERVICE. I UNDERSTAND THAT IF MY ACCOUNT SHOULD EVER REQUIRE ACTION BY A COLLECTION AGENCY OR ATTORNEY IN ORDER TO ENSURE PAYMENT, THE FEES CHARGED BY THESE AGENTS MAY BE ADDED TO THE BALANCE DUE AND UNPAID ON MY ACCOUNT. I HEREBY ACKNOWLEDGE AND AGREE TO ACCEPT THESE POLICIES STATED HERE.**

SIGNITURE:_____ DATE:_____

## AUTHORIZATIONS

**INSURANCE AND/OR MEDIGAP**

**I, THE UNDERSIGNED, AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THIS PHYSICIAN, FOR ANY SERVICES FURNISHED TO ME BY THE PHYSICIAN. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE POLICY. I ALSO AUTHORIZE YOU TO RELEASE TO MY INSURANCE COMPANY, INFORMATION CONCERNING HEALTHCARE, ADVICE, TREATMENT OR SUPPLIES PROVIDED TO ME. THIS INFORMATION WILL BE USED FOR THE PURPOSE OF EVALUATING AND ADMINISTERING CLAIMS OF BENEFITS.**

**MEDICARE**

**I, THE UNDERSIGNED, UNDERSTAND THAT THIS CLINIC ACCEPTS ASSIGNMENTS ON MEDICARE. I AGREE TO BE RESPONSIBLE FOR MY DEDUCTIBLE AND/OR ANY UNCOVERED CHARGES, AS WELL AS 20% OF THE ALLOWANCE OF COVERED SERVICES. I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO THIS PHYSICIAN FOR ANY SERVICES FURNISHED TO ME BY THE PHYSICIAN. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO "THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS" ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR BENEFITS PAYABLE FOR RELATED SERVICES.**

**MEDICAID**

**I AGREE TO BE RESPONSIBLE FOR ANY SERVICE NOT COVERED BY MEDICAID. I REQUEST THAT PAYMENT OF AUTHORIZED MEDICAID BENEFITS BE MADE ON MY BEHALF TO THE PHYSICIAN. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE DIVISION OF MEDICAID OR ITS FISICAL AGENT ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE TO RELATED SERVICES**

SIGNITURE:_____ DATE:_____