Gastroenterology & Hepatology Consultants
Patient Registration Form

Patient's Name: _____ **SSN:** _____ **Driver license #**_____

Address: _____

Apt. #:_____ **City:** _____ **State**_____ **Zip:** _____

Patient's Home Phone: (____) _____ **Work Phone:** (____) _____ **Cell Phone:** (____) _____

Sex: **M** ☐ **F** ☐ **Date of Birth:** _____ **Email:** _____

Primary Care Physician: _____**Referring Doctor:** _____

Marital Status: ☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Widowed**

Race: (please circle) American Indian, Asian, African American, Native Hawaiian or Pacific Islander, Caucasian

Other Ethnicity: (please circle) Non-Hispanic, Hispanic, Patient Decline

Emergency Contact: _____ **Relationship to Patient:**_____

Address:_____ **Phone number:**_____

Patient's Employer:_____

Is the patient the financially responsible party? _____

If No, indicate name of person who is _____**Relationship**_____

Insurance Information:

Primary Insurance :_____

Are you the Policy Holder? Y ☐ **N** ☐

If No, Indicate Subscriber's Name:_____

Subscriber Date of Birth: _____

Insurance Information:

Secondary Insurance: _____

Are you the Policy Holder? Y ☐ **N** ☐

If No, Indicate Subscriber's Name:_____

Subscriber Date of Birth: _____

Other Insurance: _____

Pharmacy Location: _____