

1640 ROUTE 88 W
SUITE 202
BRICK, NJ 08724

ATLANTIC COAST GASTROENTEROLOGY ASSOCIATES, LLC.
1944 CORLIES AVENUE
SUITE 205
NEPTUNE, NJ 07753

PATIENT REGISTRATION FORM

PLEASE PRINT:

LAST NAME: _____ FIRST NAME: _____ MI

ADDRESS :

CITY : _____ STATE: _____ ZIP:

SEX: M / F DATE OF BIRTH: _____ MARRIED/SINGLE/WIDOWED/DIVORCED/OTHER

PREFERRED LANGUAGE: _____ ETHNICITY: _____ RACE:

PATIENTS SSN: xxx-xx- YOUR SPOUSE NAME: _____

HOME PHONE: _____ WORK # _____ CELL#

EMAIL ADDRESS :

EMPLOYMENT STATUS: SELF / FI / PT / RETIRED / DISABLED / UNEMPLOYED / OTHER

PATIENTS EMPLOYER AND ADDRESS :

EMPLOYER PHONE: _____

PRIMARY CARE PHYSICIAN :

REFERRING DOCTOR :

INSURANCE INFORMATION:

INSURANCE :

INSURANCE ID#

GROUP # _____ RELATION TO SUBSCRIBER: SELF / SPOUSE / CHILD / OTHER

SUBSCRIBERS DATE OF BIRTH :

NAME OF SUBSCRIBER: _____ SSN: xx-xxx-

SUBSCRIBERS EMPLOYER:

WORK ADDRESS AND PHONE : _____

SECONDARY INSURANCE:

INSURANCE : _____

INSURANCE ID# _____ GROUP #

RELATION TO SUBSCRIBER: _____ SUBSCRIBERS DOB:

NAME OF SUBSCRIBER: _____ SSN: xxx-xx

SUBSCRIBER EMPLOYER :

EMERGENCY CONTACT INFORMATION:

EMERGENCY CONTACT PERSON OTHER THAN SPOUSE :

EMERGENCY CONTACT # _____ RELATION

EMERGENCY CONTACT WORK #

PHARMACY INFORMATION:

NAME OF PHARMACY : _____ PHONE:

ADDRESS :

DRUG ALLERGIES:

LATEX ALLERGIES: DOCUMENTED / SENSITIVE :

LIST OF CURRENT MEDICATIONS:

INSURANCE AGREEMENT: I AUTHORIZE ATLANTIC COAST GASTROENTEROLOGY ASSOCIATES, LLC. TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY TREATMENT AND ILLNESS. I REQUEST THAT PAYMENT OF BENEFITS FROM MY INSURANCE CO. BE MADE TO ATLANTIC COAST GASTROENTEROLOGY ASSOCIATES, LLC. I REQUEST THAT PAYMENT OF MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO ATLANTIC COAST GASTROENTEROLOGY ASSOC. LLC FOR ANY SERVICE FURNISHED TO ME BY PHYSICIAN OR SUPPLIER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMIN AND IT AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICE. ALL PATHOLOGY/ BIOPSY SPECIMENS THAT ARE SENT TO OUTSIDE LABS ARE THE RESPONSIBILITY OF THE PATIENT FOR ANY PROCEDURE THAT IS DONE THESE CHARGES ARE SEPERATE FROM THE PROCEDURE CHARGE.

PATIENT SIGNATURE: _____ DATE: _____

*** please note our office will submit balances overdue more than 90days to an outside collection agency.***