



Name _____ (Last, First, MI)

Address _____ City _____ State ____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth ____ / ____ / ____ Age _____ Social Security # ____ - ____ - ____

Sex: M F Marital Status: S M D W Email: _____

Language: English Spanish Other _____

Race: White Black / African American Native American / Alaska Native Asian

Native Hawaiian/ Other Pacific Islander Other _____ Unknown/ Declined

Ethnicity: Spanish/ Hispanic Origin Not of Spanish/Hispanic Origin Patient Declined/ Unknown

Patient's Employer _____ Phone # _____

Referring Doctor: _____ Phone # _____

Primary Care Doctor: _____ Phone # _____

Person to Notify in Case of Emergency:

1. Name _____

Phone _____ Cell: _____ Relationship _____

2. Name _____

Phone _____ Cell: _____ Relationship _____

Insurance Information:

Insured's Name _____ Date of Birth ____ / ____ / ____ SS # ____ - ____ - ____

Insured's Employer _____ Phone # _____

Primary insurance _____ Policy # _____ Group # _____

Relationship to Patient: Self Spouse Child Other _____

Pharmacy Information:

Pharmacy Name _____ Phone # _____

Pharmacy Address _____

I hereby authorize Buffalo Gastroenterology Associate, LLP to apply for benefits on my behalf for covered services. I request the payment be made directly to Buffalo Gastroenterology Associates, LLP. If my insurance does not cover any services, I will be responsible for payment. I certify the above information to be correct. I authorize the release of any medical information necessary to process claim. I permit a copy of this authorization to be used in place if the original. In addition, 30% of the balance will be added to any account turned over to the collection agency.

Signature _____ Date ____ / ____ / ____