Buffalo Gastroenterology Associates, LLP

Patient Information

Name (last, first)____

Address ______________________ City__________ State_____ Zip______

Home Phone______________Work Phone____________Cell Phone____________

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

Sex: M F Marital Status: S M D Email ______________________________

Patient's Employer___________________________ Phone#________________

Referring Doctor ____________________________ Phone# _______________

Primary Care Doctor: ________________________ Phone# _______________

Person to notify in case of an emergency: ____________________________

Phone____________ Cell __________ Relationship_______________________

Insured's Name ________________________ DOB ___/___/___ SS# ____-____-____

Insured's Employer __________________________ Phone#_______________

Primary Insurance ___________________ Policy # _________ Group # _________

Relationship to patient: Self ___ Spouse ___ Child ___ Other _________________

Secondary Insurance _________________ Policy # _________ Group # _________

Relationship to patient: Self ___ Spouse ___ Child ___ Other _________________

Pharmacy Name _______________________ Phone# ______________________

Pharmacy Address ____

I hereby authorize Buffalo Gastroenterology Associates, 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 of the original. In addition, 30% of the balance will be added to any account turned over to the collection agency.

Signature ____ Date ____/____/____