



**PATIENT INFORMATION**

To assist us in updating your file and processing your insurance claim, please provide the following information. We must have complete and accurate information or your insurance provider may deny or delay processing your claim. **Please have your insurance card and picture ID with you at the time of service.**

Name: \_\_\_\_\_  
                    Last  First  Middle Initial                    Title: (Mr. Mrs. Ms.)

Address: \_\_\_\_\_  
                    Street  City  State                    Zip Code

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Social Security: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Phone Number: \_\_\_\_\_

Race/Ethnicity (Circle One): American Indian Asian Black/African White Hispanic Other Decline

Preferred Language (Circle One): English Spanish Other Decline

Primary Care Physician: \_\_\_\_\_

I acknowledge receiving the Notice of Patient Privacy Practices (HIPPA) from Granite State Gastroenterology.

As a courtesy to our patients, we submit insurance claims to the Insurance Co., but we must collect copays at the time of service. I understand that it is my responsibility to provide a referral from my Primary Care Provider.

I authorize the release of any medical information necessary to process this claim. I also authorize payment of medical benefits directly to my care provider.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**\*\*\* PLEASE NOTE: OUR OFFICE WILL CHARGE A \$100 FEE FOR NO SHOW/CANCELLATION/RESCHEDULES MADE WITHIN 72 HOURS OF PROCEDURE DATE AND A \$50 FEE FOR OFFICE VISITS.**