

**Gastroenterology Specialists of Oregon, P.C.**

**PATIENT INFORMATION: (Please Print)**

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

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

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

Patient ID #: \_\_\_\_\_

Sex:  Male  Female

Date of Birth: \_\_\_\_\_

Social Security #: XXX-XX-\_\_\_\_\_

Marital Status:  Married  Single  Divorced  Widow

Referring Provider: \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_

**EMPLOYMENT:**

Employer: \_\_\_\_\_

Phone: \_\_\_\_\_

GSO will use reasonable means to protect the privacy of your health information sent by e-mail and text. However, GSO cannot guarantee that e-mail/text communications will be confidential. Additionally, GSO will not be liable in the event that you or anyone else inappropriately uses your e-mail or text messages. GSO will not be liable for improper disclosure of your health information that is not caused by GSO's intentional misconduct.

E-mail Address: \_\_\_\_\_

Is it OK to E-mail you? (circle one):    Yes    No

Is it OK to Text you? (circle one):    Yes    No

Text Message Phone #: \_\_\_\_\_

**PRIMARY INSURANCE COMPANY**

Ins Company: \_\_\_\_\_

Insured ID: \_\_\_\_\_

Policy Group #: \_\_\_\_\_

Co-pay Amount: \_\_\_\_\_

**INSURED PERSON INFORMATION**

Name: \_\_\_\_\_

Patient's Relationship to Insured: \_\_\_\_\_

Insured Person's Date of Birth: \_\_\_\_\_

Insured Party's Social Security #: XXX-XX-\_\_\_\_\_

**SECONDARY INSURANCE COMPANY**

Ins Company: \_\_\_\_\_

Insured ID: \_\_\_\_\_

Policy Group #: \_\_\_\_\_

Co-pay Amount: \_\_\_\_\_

**INSURED PERSON INFORMATION**

Name: \_\_\_\_\_

Patient's Relationship to Insured: \_\_\_\_\_

Insured Person's Date of Birth: \_\_\_\_\_

Insured Party's Social Security #: XXX-XX-\_\_\_\_\_

**INSURANCE AUTHORIZATION AND ASSIGNMENT (Please read and sign)**

I attest that the information I have given here is true and correct to the best of my knowledge. I hereby assign benefits to Gastroenterology Specialists of Oregon, PC and authorize them to furnish information regarding my treatment to my insurance company. I understand that my contract with my insurance company requires me to be compliant to the rules of my policy regarding referrals to medical specialists.

**I understand that I am responsible for all known visit co-pays at the time of service.**

Patient Signature

Date