

Gastroenterology Specialists of Oregon, P.C.

PATIENT INFORMATION: (Please Print)

Patient ID #: _____

Name: _____

Date of Birth: _____

Address: _____

Sex: Male Female

City, State, Zip Code: _____

Social Security #: XXX-XX-_____

Phone: _____ Home Work Cell

Alternate Phone: _____ Home Work Cell

Marital Status: Married Single Divorced Widowed

Primary Care Provider: _____

Referring 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.

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

*This may include billing statements, result letters, or other documents.

Is it OK to Text you? (circle one): Yes No Text Message Phone #: _____

PRIMARY INSURANCE COMPANY

INSURED PERSON INFORMATION

Ins Company: _____ Name: _____

Insured ID: _____ Patient's Relationship to Insured: _____

Policy Group #: _____ Insured Person's Date of Birth: _____

Co-pay Amount: _____ Insured Party's Social Security #: XXX-XX-_____

SECONDARY INSURANCE COMPANY

INSURED PERSON INFORMATION

Ins Company: _____ Name: _____

Insured ID: _____ Patient's Relationship to Insured: _____

Policy Group #: _____ Insured Person's Date of Birth: _____

Co-pay Amount: _____ 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: _____