

## PATIENT INFORMATION

Thank you for choosing our office. In order to serve you properly we will need the following information. All information will be strictly confidential. Please **print** in the blanks provided below.

Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_ Maiden \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Please Circle: Married Single Widowed Divorced Separated Living with parents

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_ Cellular Phone/Pager \_\_\_\_\_

### Name and telephone number of nearest relative/friend not living with you

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Email address \_\_\_\_\_

Employer name \_\_\_\_\_ Occupation \_\_\_\_\_

Referring Physician \_\_\_\_\_ Family/Primary Care Physician \_\_\_\_\_

How did you hear about us? (circle) Insurance Directory Friend/Relative Yellow Pages Physician  
Other \_\_\_\_\_

### **IF MARRIED OR MINOR, PLEASE FILL OUT THE FOLLOWING INFORMATION:**

Full name of your spouse or guardian \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Social security number of your spouse or guardian \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work Phone # \_\_\_\_\_

Occupation of your spouse or guardian \_\_\_\_\_ Employed by \_\_\_\_\_

### **INSURANCE COVERAGE:**

**If the name of the policy holder is someone other than the patient, please indicate the name and social security number of the policy holder below for both primary and secondary coverage:**

#### **(Primary)**

Name of policy holder \_\_\_\_\_ Social security number of policy holder \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

#### **(Secondary)**

Name of policy holder \_\_\_\_\_ Social security number of policy holder \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### **PATIENT'S OR AUTHORIZED SIGNATURE:**

I hereby irrevocably assign and transfer to Iberia Gastroenterology Associates, Inc. any and all benefits to which I am entitled or which are available to me under any medical, health and accident, or workers' compensation policy, plan, or program. I hereby authorize and direct that any such payments be paid directly to Iberia Gastroenterology Associates, Inc. I hereby further assign and transfer to Iberia Gastroenterology Associates, Inc. any and all rights under La. R.S. 22:657(A), La. R.S. 23:1201.2, 29 USCA 1132, or any similar statutes for penalties, attorneys fees and costs for failure of any insurance company, or medical, health and accident, or workers' compensation policy, plan, or program to timely pay a claim for services rendered to me. I further authorize and agree that a carbon or photostatic reproduction of this assignment shall be effective as an original. I also authorize any overpayment due to me on this account, first be credited to any outstanding patient share balances that I have incurred. Should my account be referred to a collection agency for collection, I will assume responsibility for all collection and/or attorney fees incurred.

Signature \_\_\_\_\_ Date \_\_\_\_\_

\*\*\*\*\* ALL SERVICES ARE PAYABLE AT THE TIME OF THE VISIT \*\*\*\*\*