PATIENT INFORMATION SHEET

Patient Name: ____ Acct #: _______________

Last First Middle Initial

Address: _______________________________________ City/State/Zip: ____________________________

Home Phone: ______________________________ Cell Phone: _____________________________

Email Address: ______________________________________ SSN: ___________________________

Gender: □ Male □ Female Date of Birth: ______________________ Age: _____________

Marital Status: □ Single □ Married □ Divorced □ Widowed

Occupation Status: □ Unemployed □ Employed □ Retired □ Disabled

Emergency Contact: ___________________________________ Phone Number: ______________________

Who referred you? ___________________________ Primary Care Physician: ________________________

Have you seen a provider at WV Gastro & Endo before? □ Yes □ No

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Primary Insurance: ____

Policy Holder Name : _____________________________ DOB: _____________ SSN: ___________________
(If not yourself)

Policy Holder's Relationship to Patient: □ Spouse □ Parent □ Other: ____________________

Secondary Insurance: ____

Policy Holder Name : _____________________________ DOB: _____________ SSN: ___________________
(If not yourself)

Policy Holder's Relationship to Patient: □ Spouse □ Parent □ Other: _____________________

Which Pharmacy do you use? _______________________________ City? ___________________________

Your copay and deductibles are due at the time of service. By signing this, you agree to be responsible for any charges that your insurance company does not pay after assignment is accepted. You are giving us authorization to bill Medicare and/or any other insurance company that you are covered by. This authorization applies to all occasions of service until it is revoked by the patient or an authorized representative in writing.

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Signed by patient or authorized representative Date