MARIN GASTROENTEROLOGY & THE ENDOSCOPY CENTER OF MARIN
PATIENT INFORMATION

(PLEASE PRINT)

PATIENT'S **LAST** NAME (AS SHOWN ON INSURANCE / MEDICAL RECORDS)	FIRST NAME	M.I.	MALE FEMALE

DATE OF BIRTH (MM/DD/YY)	SOCIAL SECURTIY NUMBER	MARITAL STATUS	CELL / PAGER (OPTIONAL)

MAILING ADDRESS	CITY	STATE	ZIP CODE	HOME PHONE

OCCUPATION	EMPLOYER NAME AND CITY LOCATED	BUSINESS PHONE

REFERRING PHYSICIAN NAME: CITY LOCATED:	GASTROENTEROLOGIST (CHECK ONE) : BLOOM VARNER McAULIFFE ☐ KAO ☐ SOWERBY ☐ LEE ☐ BETTINGER

PRIMARY CARE / FAMILY PHYSICIAN NAME: CITY LOCATED:	EMERGENCY CONTACT (OTHER THAN SPOUSE) NAME & RELATIONSHIP	PHONE

SPOUSE'S **LAST** NAME (AS SHOWN ON INSURANCE / MEDICAL RECORDS)	FIRST NAME (NO NICKNAMES PLEASE)	M.I.	DATE OF BIRTH

Do you have an advanced medical directive? Yes No If yes, Name: ______________________________ Phone: _______________

Would you like information on advance directives? Yes No

IT IS A STATE REQUIREMENT FOR THE ENDOSCOPY CENTER OF MARIN TO REPORT THE FOLLOWING INFORMATION:

RACE (check one): American Indian Asian Black or African American Native Hawaiian White Other Race Unknown
ETHNICITY (check one): Hispanic or Latino Non-Hispanic or Non-Latino Unknown

INSURANCE INFORMATION: PLEASE GIVE INSURANCE CARD(S) TO THE RECEPTIONIST

In order to bill your insurance company on your behalf we must have a current copy of your insurance card on file. Please give your current insurance card(s) to the receptionist. Note: You will be asked at every visit for your insurance card(s) and of any changes to the information on this form. Thank you for your cooperation and assistance in maintaining your medical records.

NAME OF PRIMARY INSURANCE	NAME OF SUBSCRIBER	DATE OF BIRTH	RELATIONSHIP
NAME OF SECONDARY INSURANCE	NAME OF SUBSCRIBER	DATE OF BIRTH	RELATIONSHIP

BENEFIT ASSIGNMENT & ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY:

I authorize the above named insurance companies to make payment directly to Marin Gastroenterology on my claim for medical services provided to me or my dependants. I understand that I am financially responsible for payment of all non-covered services, co-pays, deductibles and any other charges my insurance company deems my responsibility.

Signature:____ Relationship:____________________ Date: _____________________

RELEASE OF RECORDS:

I hereby authorize the **release** of information, verbal and written, contained in my medical record to my insurance company and related healthcare providers only as it relates to my treatment. In addition, I hereby authorize Marin Gastroenterology to **obtain** medical records and/or professional information from my physician or other medical professional only as it relates to my treatment.

TREATMENT AUTHORIZATION AND FINANCIAL AGREEMENT:

I authorize the treatment of patient named above and agree to pay all charges at the time services are rendered unless other arrangements have been agreed upon in advance. If payment of my account is over 60 days late, or it goes to collection, all fess, including collection fees, attorney fees, and finance charges (18% APR) will be my responsibility. I understand that I may be charged a fee if I do not keep my appointments or fail to give advance notice of cancellation (1 business day for office visits, 2 business days for procedures).

Signature:____ Relationship:_____________________ Date: ____________________