Office Use Only

Patient Name _____

ID#:_____ Physician #:_____ Date: _____

Demographic Information

Patient Information

Last Name	First Name	Middle Initial	Home Phone: □Preferred ( )	Cell Phone: □Preferred ( )
Work Phone: □Preferred ( )	Street Address		City	State / Zip Code
Gender: □ M □ F	Marital Status: □ Single □ Married □ Widowed □ Divorced	Date of Birth:	Age	Maiden or former last name:
Race: □ Caucasian □ African/American □ American Indian/Eskimo □ Hispanic □ Asian/Pacific Islander □ Other			Ethnicity: □ Hispanic □ Not Hispanic	Preferred Language: □ English □ Spanish □ Other
Nickname/Preferred to be called:	Employer:		Email:	
Spouse Name:	Spouse Phone:		Parent/Guardian Name:	Parent Phone:
Emergency Contact:	Emergency contact Phone:		Relationship to Patient:	

Insurance Information

Please provide information below regarding the primary cardholder for your insurance

Last Name	First Name	Middle Initial	Home Phone: □Preferred ( )	Cell Phone: □Preferred ( )
Work Phone: □Preferred ( )	Street Address		City	State / Zip Code
Date of Birth:	Gender: □ M □ F	Social Security Number:	Email:	
Patient's relationship to Insured: □ Self □ Spouse □ Child □ Other	Employer:			
Primary Insurance Company Name			Secondary Insurance Company Name	

Is Responsible Party same as above Insurance Information? □ Yes □ No If No please provide information below:

Last Name	First Name	Middle Initial	Home Phone: □Preferred ( )	Cell Phone: □Preferred ( )
Work Phone: □Preferred ( )	Street Address		City	State / Zip Code

Release of Information

I hereby authorize Kansas Gastroenterology, LLC to release information requested by my insurance company or Worker's Compensation carrier, to any hospital or physician this office may refer me to. I hereby authorize assignment and payment directly to Kansas Gastroenterology, LLC medical benefits due me.

Signature: X Date: / /