CHARLOTTE GASTROENTEROLOGY & HEPATOLOGY, P.L.L.C.

www.charlottegastro.com
(704) 377-4009

Date _____
Doctor _____
Account No. _____

PATIENT'S SECTION

_____ (LAST NAME) _____ (FIRST NAME AND MIDDLE INITIAL) _____ (NAME PREFERENCE)

Residence Address _____ (NO) (STREET) (CITY OR TOWN) (STATE, ZIP CODE)

Mailing Address _____ (STREET) (CITY OR TOWN) (STATE, ZIP CODE)

Email _____

Last Previous Address (within past two years) _____

Social Security No. _____ Home Phone (Area Code) _____

Mobile Phone (Area Code) _____

Age _____ Sex _____ Date of Birth _____ (MONTH) (DAY) (YEAR) Birthplace _____

Please check one: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Patient's Employer _____ Position _____

Employer's Address _____ Phone No. _____ (Area Code)

Name of Spouse _____ Employer _____

Employer's Address _____ Phone No _____ (Area Code)

Emergency Contact _____ Relationship _____ Phone No. _____ (Area Code)

If you are unavailable, and we must contact you regarding lab results or appointments, with whom may we speak? _____

With whom should we speak after any procedure? _____

Address _____ Phone No. _____ (Area Code)

Nearest Relative (not living with you) _____ Relationship _____

Address _____ Phone No. _____ (Area Code)

How did you hear about our practice? ❑ Physician Referral ❑ Friend ❑ Newspaper, Magazine, (name) _____

Race: ❑ American Indian ❑ Asian ❑ Black/African American ❑ Native Hawaiian/Pacific Islander ❑ Caucasian ❑ Other

Ethnicity: ❑ Non-Hispanic ❑ Hispanic

RESPONSIBLE PARTY

PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT

Bill to: ❑ Self ❑ Spouse ❑ Parent ❑ Other (Skip below if self)

Name _____ Relationship _____ SS# _____

Address _____ Phone No. _____ (Area Code)

Employer _____ Position _____

Address _____ Phone No. _____ (Area Code)

MEDICAL INSURANCE INFORMATION

Primary Insurance Co. _____

Address _____

_____

Policy No _____ Group No _____

Policy Holder _____ Date of Birth _____

Policy Holder's SSN# _____

Relationship to Patient: _____

Secondary Insurance Co. _____

Address _____

_____

Policy No _____ Group No. _____

Policy Holder _____ Date of Birth _____

Relationship to Patient: _____

Other _____

REFERRAL INFORMATION

_____
REFERRING DOCTOR'S NAME (REF. DR. PHONE NO.)

_____
REFERRING DOCTOR'S ADDRESS

I authorize any holder of medical or other information about me to release to insurance carriers, the Social Security Administration and Health Care Financing Administration (or its intermediaries or carrier), and/or any physician CGH refers me to , or any information needed for this or a related insurance and/or Medical claim.

I hereby assign to the physicians all payments for hospital/medical/surgical services rendered to myself or my dependents.

I understand that I am responsible for any amount not paid for by insurance.

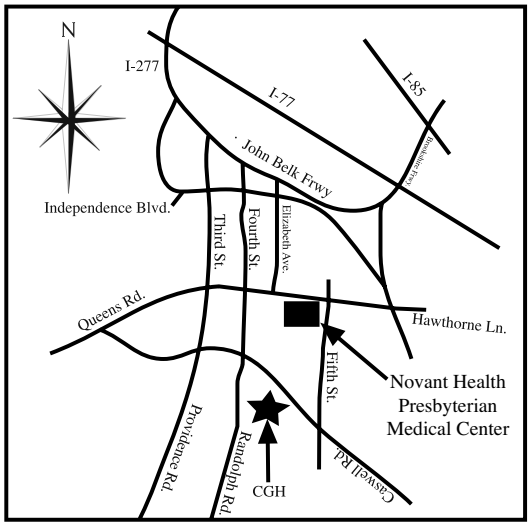
I understand that Charlotte Gastroenterology & Hepatology, P.L.L.C., accepts Medicare assignment for Medicare claims and all regulations pertaining to Medicare assignment and benefits apply.

I have read (or had read to me) all of the above and understand all parts of this authorization.

_____
PATIENT'S NAME DATE

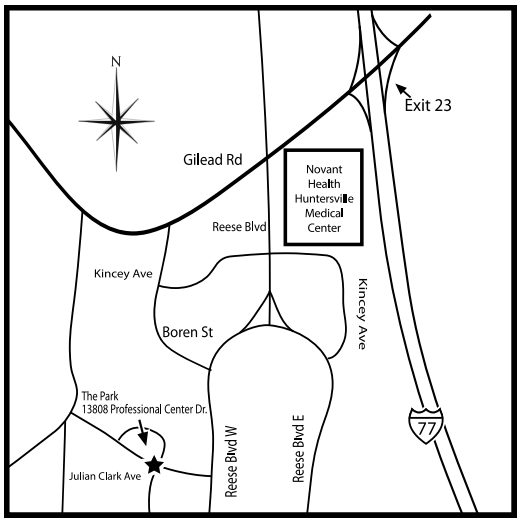
Charlotte Office

2015 Randolph Road, Suites 101 & 208
Charlotte, NC 28207



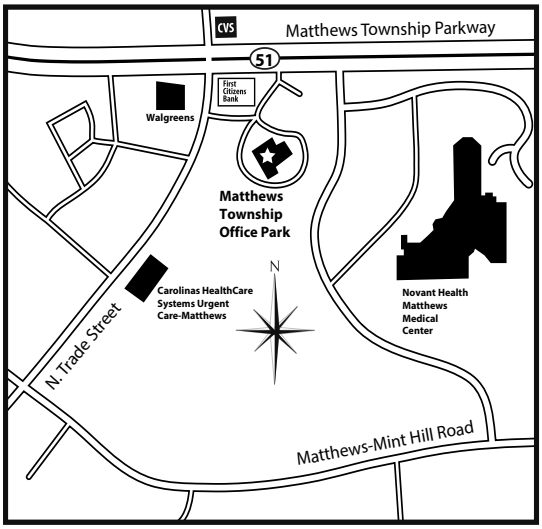
Huntersville Office

13808 Professional Center Dr.
Huntersville, NC 28078



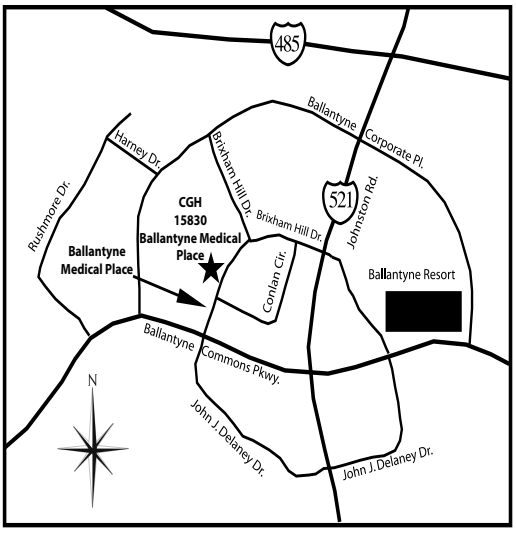
Matthews Office

Matthews Township Office Park
1340 Matthews Township Pkwy., Ste. 301
Matthews, NC 28105



Ballantyne Office

15830 Ballantyne Medical Place, Suite 175
Charlotte, NC 28277



Mooresville Office

115 Commerce Pointe Blvd.
Mooresville, NC 28117