FGA | FREDERICK GASTROENTEROLOGY ASSOCIATES FEC | FREDERICK ENDOSCOPY CENTER

Patient Registration Form

Please complete ALL fields:

Patient's Name (Last, First, MI): _____

Patient's Home Phone: _____ Cell Phone: _____ Daytime/Work: _____

Address: _____ Apt/Unit#: _____

City: _____ State: _____ Zip Code: _____

E-Mail Address: _____

Date of Birth: _____ / _____ / _____ Age: _____ Sex: M ____ F____ Marital Status: S ___ M ___ D___ W__

Social Security #: _____-_____-_____ Primary Care Physician: _____

INSURANCE INFORMATION (Please check all that apply)
Primary Insurance: Yes ____ No ____ Secondary Insurance: Yes ____ No ___ Tertiary Insurance: Yes ___ No____

Primary Insurance Carrier: _____

Primary Insurance Carrier ID#: _____ Group/Plan #: _____

Subscriber's Name (if not patient): _____Date of Birth: _____

Secondary Insurance Carrier: _____

Secondary Insurance Carrier ID #: _____Group/Plan #: _____

Subscriber's Name (if not patient): _____ Date of Birth: _____

Tertiary Insurance Carrier: _____

Tertiary Insurance Carrier ID #: _____Group/Plan #: _____

Subscriber's Name (if not patient): _____ Date of Birth: _____

Acknowledgement of Insurance Practices

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I request the payment of insurance benefits (including Medicare benefits) be made on my behalf to Frederick Gastroenterology Associates, Frederick Endoscopy Center and their physicians for any services furnished by me. I authorize the use of my Protected Health Information (PHI) for payment, treatment and/or Health Care Operations. Either my insurance carrier or I may revoke this authorization at any time in writing. I accept responsibility for any and all charges not paid by my insurance.

Signature **Printed Name** **Date**

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge receipt of Frederick Gastroenterology Associates and Frederick Endoscopy Center's Notice of Privacy Practices

Signature **Printed Name** **Date**