**Gastroenterology and Hepatology Specialists, Inc**
**4360 Fulton Rd. NW**
**Suite B**
**Canton, OH 44718**
**(330) 305-2020**

# PATIENT REGISTRATION

Please print in blue or black ink.
Bring papers with you to your appointment.
Bring your most current insurance card to your appointment.

PATIENT NAME: _____DATE OF BIRTH: _____SSN:_____

SEX: MALE ___ FEMALE ___ MARITAL STATUS: MARRIED ___ SINGLE ___ DIVORCED ___ WIDOWED ___

ADDRESS: _____ HOME PHONE: _____

_____ CELL PHONE: _____

NAME OF SPOUSE: _____ WORK PHONE: _____

EMAIL ADDRESS: _____ PREFERRED CONTACT: HOME ___ CELL ___ WORK ___

EMPLOYER: _____ EMPLOYER ADDRESS: _____

RETIRED YES ___ NO ___ _____

#1 EMERGENCY CONTACT NAME: _____RELATION: _____

EMERGENCY CONTACT PHONE: _____

#2 EMERGENCY CONTACT NAME: _____RELATION: _____

EMERGENCY CONTACT PHONE: _____

PRIMARY LANGUAGE SPOKEN: _____PRIMARY LANGUAGE SPOKEN AT HOME: _____

MILITARY EXPERIENCE: YES ___ NO ___ IF YES, EXPLAIN: _____

EDUCATION: HIGH SCHOOL/GED ___ SOME COLLEGE ___ COLLEGE GRADUATE ___

CURRENTLY ENROLLED IN SCHOOL? YES ___ NO ___ IF YES, EXPLAIN: _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

REFERRING PHYSICIAN: _____ PHONE: _____

DOES YOUR INSURANCE REQUIRE A WRITTEN REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN TO BE SEEN IN OUR OFFICE? YES ___ NO ___ IF YES, IT IS YOUR RESPONSIBILITY TO MAKE SURE REFERRALS ARE IN PLACE BEFORE YOUR SCHEDULED APPOINTMENT WITH OUR PRACTICE.

**INSURANCE INFORMATION**: Please give us all pertinent insurance information regarding your coverage. If you have coverage by more than one carrier, give information for both carriers in the spaces provided. We will file a maximum of 2 insurance claims per service date. Be sure to bring your insurance card(s) with you to your appointment. Please note: IF YOUR COVERAGE IS CONTINGENT ON A REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN OR IF A PRECERTIFICATION IS REQUIRED, THEN IT IS YOUR RESPONSIBILITY TO INFORM US OF THIS.

**PRIMARY CARRIER:** _____ ID#_____

CLAIMS ADDRESS: _____ GROUP #: _____

_____ EFFECTIVE DATE: _____

WHO IS THE POLICY HOLDER ON THIS INSURANCE: _____

RELATIONSHIP TO PATIENT: _____ POLICY HOLDER DATE OF BIRTH: _____

POLICY HOLDER SOCIAL SECURITY NUMBER: _____

**SECONDARY CARRIER**: _____ ID #_____

CLAIMS ADDRESS: _____ GROUP #: _____

_____ EFFECTIVE DATE: _____

WHO IS THE POLICY HOLDER ON THIS INSURANCE: _____

RELATIONSHIP TO PATIENT: _____ POLICY HOLDER DATE OF BIRTH: _____

POLICY HOLDER SOCIAL SECURITY NUMBER: _____

**RESPONSIBLE PARTY INFORMATION (who to balance bill, if other than patient)**

NAME: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____ SSN: _____ DOB: _____

_____ EMPLOYER: _____

HOME NUMBER: _____ WORK NUMBER: _____

CELL NUMBER: _____

In order to submit a claim for payment for services rendered under your policy, we must have authorization to release medical information to your insurance carrier.

**MEDICARE PATIENTS**: I request that payment of authorized Medicare benefits be made to GHS for any services rendered to me by those physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits made payable for related services. I hereby authorize Medicare to furnish the above named doctors any information regarding any Medicare claim under Title XVIII of the Social Security Act.

**COMMERCIAL INSURANCE PATIENTS**: I hereby authorize release of information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME, TO THE DOCTOR OR GROUP INDICATED ON THE CLAIM. This assignment is only revocable in writing by me. I understand and acknowledge that the medical record may contain information regarding psychiatric disorders, Human Immune Virus (HIV) results, Acquired Immune Deficiency Syndrome (AIDS), AIDS related conditions, alcohol and/or drug dependence/abuse. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE CARRIER. I have read all the information on this form and my answers are true and correct to the best of my knowledge.

**A copy of this signature is as valid as the original Patient Signature** _____

**NOTE: Signature is required in order to submit your insurance claims. If you refuse to sign, then we will require payment at time of service. Thank you for your cooperation.**