

**DECATUR GASTROENTEROLOGY ASSOCIATES, P.C.**

Appointment Date: \_\_\_\_\_

Appointment Time: \_\_\_\_\_

**Appointment with: (circle one)    Wang    Yousuf    Short**

**PLEASE FILL OUT COMPLETELY**

Patient's First Name		Middle	Last
Street Address		Apt #	City, State, Zip
Home Phone		Cell phone	Work phone
Date of Birth	Patient's Sex M    F	Patient's Social Security No.	Marital Status M    S    W    D
Patient's Employer			City, State
Which physician referred you?			City, State
Who is your family physician?			City, State

Spouse's Name	Spouse's Date of Birth	Spouse's Social Security No:
Spouse's Employer	City, State	Work Phone

Name of Insurance Company	Copay Amount \$
Policy Holder's Name	Policy Holder's DOB
	Policy Holder's Social Security No

**Emergency Contact (Other than spouse)**

Name	Relationship	Home Phone
Address	City, State, Zip	Cell Phone

I hereby agree to pay any and all charges submitted by Decatur Gastroenterology Associates, P.C (DGA) for services rendered. I hereby assign any and all benefits due me to the above named corporation. I agree that should the amount allowed by my insurance be insufficient to cover the entire amount, I will be responsible to the above named for the balance not covered by my insurance. Should this service not be covered by my insurance, or in the case I do not have insurance, I will be responsible for the entire fee for services rendered. Should my account be referred to our collection agency, a collection cost may be added to the amount due. I hereby authorize DGA to release to my insurance carrier, sponsoring agency, social security administration or its intermediaries or carriers, information requested by them and needed for processing of benefits claims.

I undertake to be a full, responsible participant in my own health care and that should I fail to return for recommended care at the recommended time, that notation will be made in my medical chart.

Comments: To the best of my knowledge the above confidential information is true. I hereby give consent for treatment, and if above named patient is a minor, I also give consent for his/her treatment.

DATE \_\_\_\_\_ SIGNED \_\_\_\_\_