



Michigan Gastroenterology Institute

An Affiliate of Michigan State University

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PATIENT NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

ADDRESS \_\_\_\_\_ (STREET) \_\_\_\_\_ (CITY) \_\_\_\_\_ (ZIP)

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

GENDER: M F SOC. SECURITY # \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_ (OPTIONAL)

RACE: \_\_\_\_\_ ETHNICITY: \_\_\_\_\_ LANGUAGE \_\_\_\_\_

EMAIL: \_\_\_\_\_

If you provide your email address we will send you patient data via secured patient portal

FAMILY PHYSICIAN \_\_\_\_\_ PHONE: \_\_\_\_\_

ADDRESS \_\_\_\_\_ (STREET) \_\_\_\_\_ (CITY) \_\_\_\_\_ (ZIP)

REFERRING PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_ (STREET) \_\_\_\_\_ (CITY) \_\_\_\_\_ (ZIP)

PRIMARY INSURANCE \_\_\_\_\_ CONTRACT # \_\_\_\_\_

SUBSCRIBER \_\_\_\_\_ SUBSCRIBER BIRTHDATE \_\_\_\_\_

EMPLOYER \_\_\_\_\_

SECONDARY INSURANCE \_\_\_\_\_ CONTRACT # \_\_\_\_\_

SUBSCRIBER \_\_\_\_\_ SUBSCRIBER BIRTHDATE \_\_\_\_\_

EMPLOYER \_\_\_\_\_

EMERGENCY CONTACT (Other than spouse) \_\_\_\_\_ PHONE \_\_\_\_\_

PLEASE COMPLETE THE FOLLOWING IF THE PATIENT IS A MINOR

MOTHER'S NAME \_\_\_\_\_ PHONE \_\_\_\_\_

FATHER'S NAME \_\_\_\_\_ PHONE \_\_\_\_\_

WE BILL AND ACCEPT MOST INSURANCE COMPANIES' USUAL AND CUSTOMARY FEES. YOU WILL BE RESPONSIBLE FOR ANY DEDUCTIBLE AND CO-PAY AMOUNTS. PLEASE ASK OUR RECEPTIONISTS IF YOU HAVE ANY QUESTIONS REGARDING YOUR COVERAGE.

I UNDERSTAND THAT UNDER THE HIPAA GUIDELINES THAT MY INFORMATION MAY BE RELEASED TO OTHER PROVIDERS INVOLVED IN MY CARE FOR THE PURPOSES OF TREATMENT, PAYMENT, OR OPERATIONS. I AUTHORIZE THAT PAYMENT BE MADE DIRECTLY TO MICHIGAN GASTROENTEROLOGY INSTITUTE, TIN #38-3359571. A COPY OF THIS SIGNATURE AND STATEMENT SHALL BE AS VALID AS THE ORIGINAL.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_