Michigan
Gastroenterology
Institute
An Affiliate of Michigan State University

1650 RAMBLEWOOD DRIVE
EAST LANSING, MI 48823
517. 332 .1200 / FAX 517. 351. 3327 / www.michigangastro.com

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 _____