GASTRO SURGI CENTER OF NEW JERSEY LLC
PATIENT INFORMATION

In order to serve you properly, we need the following information. **Please print.** All information will be confidential. **Correct information is essential to avoid decline or delay in payment.** Please bring your insurance ID/Medicare cards with you.

Date:__________ Patient Name: ______________________________ Patient #: ________________
First MI Last

SS# / SIN: ____________________ ❑ Male ❑ Female Birth Date: __________ Home Phone: __________

Address:________________________ City: ____________________ State/Prov: ______ Zip/P.C.________

E-Mail: ________________________________ Cell Phone:____________________

Check appropriate box: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Patient's or Parent/Guardian's Employer ____________________________ Work Phone: ______________

Business Address: ____________________ City: ____________________ State/Prov: ______Zip/P.C.________

Spouse's Name: ____________________ Employer: ____________________ Work Phone: ______________

Person to contact in case of an emergency? ____________________________Phone: ______________

Responsible Party

Name of person responsible for this account: ________________________Relationship to Patient:____________

Address:________________________________ Home Phone: ____________________
(If different from patient)

E-Mail: ________________________________ Cell Phone:____________________

Driver's License #: ____________________ Birth Date:__________Financial Institution:________________

Employer Name:____________________________ Work Phone:____________________

Insurance Information (Primary)

Name of Insured: ________________________Relationship to Patient:____________________

Birth Date: __________ SS#/SIN:________________________________Effective Date:______________

Employer Name:____________________________ Work Phone:____________________

Employer Address:____________________ City: ____________________ State/Prov: ______ Zip/P.C. ________

Insurance Co: ________________________________ID#: ____________________ Group #: ____________

Insurance Co. Address:__________________ City: ____________________ State/Prov: ______ Zip/P.C. ________

How much is your deductible? __________ How much have you used: __________Max. Annual Benefits? __________

Do you have any additional insurance? ❑ Yes ❑ No If "yes", please complete the following:

Seconday Insurance Information

Name of Insured: ________________________________ Relationship to Patient: ____________

Birth Date: __________ SS#/SIN:________________________________Effective Date:______________

Employer Name:____________________________ Work Phone:____________________

Employer Address:____________________ City: ____________________ State/Prov: ______ Zip/P.C. ________

Insurance Co: ________________________________ID#: ____________________ Group #: ____________

Insurance Co. Address:__________________ City: ____________________ State/Prov: ______ Zip/P.C. ________

How much is your deductible? __________ How much have you used: __________Max. Annual Benefits? __________

I authorize release of any information concerning my health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor. You are responsible for the balance not paid by your insurance and any applicable deductible, insurance and co-payment.

____ ____________________

Signature of patient or parent / guardian, if a minor Date

MEDICATION FORM

Name:____

Date:____________________

Please fill out this form with all medications you take. Example: prescriptions, samples, vitamins, over the counter drugs, vaccines, diagnostic and contrast agents, radioactive meds, respiratory therapy-related meds, parenteral nutrition, blood derivatives, IV solutions, and any products designated by the FDA as a drug.

List completed by: ____ Patient _____ Family Member ____ Other

Name of Medication	Dosage	Frequency	What is the drug used for?

IF YOU NEED AN INTERPRETER

If you will need an interpreter, please let us know and one will be provided for you. If you have someone who can translate confidential, medical, and financial information for you please let us know and they may accompany you on the day of your procedure.