West Gastroenterology Medical Group

PATIENT INFORMATION FORM

LAST NAME/APELLIDO	FIRST NAME/PRIMER NOMBRE	MIDDLE NAME
DRIVERS LIC./ID NUMBER	BIRTH DATE/FECHA DE NACIMIENTO	GENDER/SEXO □ Male □ Female □ Other
ADDRESS/DOMICILIO	CITY/CIUDAD	ZIPCODE/CODIGO POSTAL
RACE/RAZA	LANGUAGE/LENGUAJE	ETHNICITY/ETNICIDAD □ Hispanic or Latino □ Not Hispanic Or Latino □ Other
MARITAL STATUS /ESTADO CIVIL □ Single □ Married □ Divorced □ Widowed	DAYTIME NUMBER/NUMERO TELEFONICO DE DI (_____)_____-_____	CELL PHONE NUMBER/NUMERO DE CELULAR (_____)_____-_____
HOME NUMBER/NUMERO DE HOGAR (_____)_____-_____	EMAIL ADDRESS/DOMICILIO DE CORREO ELECTRONICO _____@_____	
PRIMARY CARE PROVIDER/DOCTOR DE CABEZERA	REFERRING PROVIDER	
NAME OF PERSON TO BE NOTIFIED IN EMERGENCY/NOMBRE DE PERSONA PARA CONTACTAR EN CASO DE EMERGENCIA		
PHONE NUMBER/NUMERO DE TELEFONO		

INSURANCE NAME/NOMBRE DE ASEGURANZA	POLICY NUMBER ON CARD/NUMERO DE POLICA
RELATIONSHIP TO INSURED/RELACION A PERSONA ASEGURADA □ SELF □ SPOUSE □ CHILD □ OTHER	INSURED'S NAME/NOMBRE DE PERSONA ASEGURADA

I consent to treatment as necessary or desirable to the care of the patient named above, including but restricted to whatever drugs, medicine, performance of operations, laboratory, x-ray or other studies that may be used by the attending doctor, his nurse or qualified designate.
I further understand that the qualified designated in some cases will be the Assistant to the Primary Care Physicians, also called a PA/NP.
An assistant to the Primary Care Physicians means a person who is graduate of an approval program of instruction in Primary Health Care perform and is approved by the Board to direct patient care services under the supervision of a Primary Care Physician.
I acknowledge full responsibility for the payment of such services and agree to pay for them, in full, AT THE TIME OF SERVICE. If payment is not received within sixty (60) days of service, a finance charge of 1 1/2% per month will be applied to the unpaid balance. If the physicians must use a a collection agency/attorney/or court to collect its charges, then I will pay reasonable attorney fees, and costs, incurred in collecting same, regardless of insurance coverage.
I hereby authorize payments directly to **West Gastroenterology Medical Group** of the Medical Expense benefits otherwiese payable to me but not exceed my indebtedness to said physician on account of the enclosed charge.
PATIENTS OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED/FIRMA:_____ DATE/FECHA:_____

INSURED OR AUTHORIZED PERSON'S SIGNATURE/FIRMA:_____ DATE/FECHA:_____