Carolina Mountain Gastroenterology
A Division of Digestive Health Partners, P.A.

Patient Information Sheet

Date: _____ **Patient #** _____(Office use only)

Patient Info.

Name: _____ **(Maiden if Married)**_____

Address: _____ **DOB:** _____ **Sex:** _____ **SS#**_____

City:_____ **State:**_____ **Zip:**_____ **Phone:**_____ **Cell:**_____

Email:_____ **Marital Status:**_____

Race:
- o Caucasian
- o Black or African American
- o American Indian
- o Asian
- o Native Hawaiian or Pacific Islander
- o Other
- o Declined /Unavailable

Ethnicity:
- o Hispanic
- o Non-Hispanic
- o Declined / Unavailable

Preferred Language: _____

Emergency Contact: _____ **Phone**: _____

Relationship to contact: _____

Employer Status: ☐ EMPLOYED ☐ STUDENT, FULL TIME ☐ STUDENT, PART TIME ☐ OTHER

Employer: _____ **Work Phone**:_____

Occupation: _____
(If Student, List School Name)

Referring Physician: _____ **Phone**: _____

Primary Care Physician:_____ **Phone**:_____

Spouse Info

Name:_____ **DOB:** _____

SS# _____ **Cell:** _____ **Work Phone:**_____

Insurance Info

Subscriber's Name:_____ **DOB:**_____

Primary Insurance:

Company:_____ **ID#** _____ **Group#** _____

Secondary Insurance:

Company:_____ **ID#** _____ **Group#** _____

I hereby authorize the release of any medical information necessary for the processing of Insurance. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled to Carolina Mountain Gastroenterology, a Division of Digestive Health Partners, P.A., This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

I understand that reduction or rejection of a claim by my insurance company does not relieve me of the financial obligation I have incurred.

I understand that a charge of $75 for an office visit and $250 for procedures will be billed to me for cancellations within 1 business day of the appointment or for not showing to my appointment. This charge MUST be paid before another appointment can be scheduled.

Patient Name: *(Please Print)* _____

Signature: _____ **Date:** _____