Carolina Mountain Gastroenterology

PATIENT INFORMATION SHEET **DATE:** _____

Please verify all information and make corrections.

You can also create an account and update your info online at **www.Caromtngastro.com**

PATIENT INFO.

PATIENT # _____ (Office Use Only)

Name: _____ **(Maiden)** _____

Address: _____ **D.O.B.** : _____ **Sex:** _____ **S.S.#:** _____

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

Email: _____ **Marital Status:** _____

Race:

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

Ethnicity:

- ☐ Hispanic
- ☐ Non-Hispanic
- ☐ Declined/Unavailable

Preferred Language: _____

EMERGENCY CONTACT: _____ **PHONE#:** _____

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: _____ **D.O.B.:** _____ **SS#** _____ **CELL#:**_____

EMPLOYER: _____ **WORK#:** _____

INSURANCE INFO.

SUBSCRIBER'S NAME:_____ **DOB:**_____ **SS#**_____

PRIMARY INSURANCE: _____	**SECONDARY INSURANCE:** _____
ID # _____ **GRP#**_____	**ID #** _____ **GRP#**_____

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, 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.

PATIENT NAME: (*PLEASE PRINT*) _____

SIGNATURE: _____ **DATE:** _____

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

SIGNATURE: _____ **DATE:** _____