

HARFORD GASTROENTEROLOGY ASSOCIATES, P.A.
Physicians Pavilion II
510 Upper Chesapeake Drive, Suite 416
Bel Air, Maryland 21014
443-643-4700

HARFORD ENDOSCOPY CENTER
2 North Avenue, Suite 102
Bel Air, Maryland 21014
410-838-6345
www.harfordendoscopy.com

HARFORD GASTROENTEROLOGY ASSOCIATES, P.A.
251 Lewis Lane, Suite 105
Havre de Grace, Maryland 21078
410-939-5082

PATIENT INFORMATION SHEET

NAME _____ SS # _____ - _____ - _____
LAST FIRST MI
ADDRESS _____ DATE OF BIRTH _____ - _____ - _____
CITY _____ STATE _____ ZIP CODE _____ MARITAL STATUS: S M
HOME PHONE _____ WORK PHONE _____ D W
EMPLOYER _____ SEX: Male Female
(If retired-give name of company) DRUG ALLERGIES: _____
ADDRESS _____
REFERRING PHYSICIAN _____
ADDRESS / PHONE _____

WHOM TO NOTIFY IN CASE OF EMERGENCY

NAME _____ RELATIONSHIP _____
ADDRESS _____ HOME PHONE _____
CITY _____ STATE _____ ZIP CODE _____ WORK PHONE _____

Please Check off the following. This information is requested by the Department of Health and Mental Hygiene, for Statistical reporting purposes only. Your response is appreciated.

ETHNICITY

1. African American 2. American Indian/Eskimo 3. Asian 4. Hispanic Pacific Islanders 6. Caucasian 7. Other

PRIMARY INSURANCE

COMPANY _____ **POLICY HOLDER'S**
ADDRESS _____ NAME _____ SS # _____ - _____ - _____
DATE OF BIRTH _____ POLICY# _____
PHONE _____ EMPLOYER _____ GROUP # _____

SECONDARY INSURANCE

COMPANY _____ **POLICY HOLDER'S**
ADDRESS _____ NAME _____ SS # _____ - _____ - _____
DATE OF BIRTH _____ POLICY# _____
PHONE _____ EMPLOYER _____ GROUP # _____

DISCLOSURE AGREEMENT

I have been informed by the physician and Center that the physician who is rendering services has an ownership interest in the above referenced facility. The physician has given me the option to be treated at another facility, which I have declined. I wish to be treated at the above referenced facility.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize release of any medical information necessary to process any insurance claims and I authorize payment of medical benefits directly to HARFORD GASTROENTEROLOGY ASSOCIATES, P.A. / HARFORD ENDOSCOPY CENTER for myself or my dependents. I understand that I am responsible for any Deductibles, Co-insurances, Co-pays, or other amounts not covered by my insurance companies. If a referral is required and is not presented at the time of service, service will be denied until the referral is obtained.

DATE _____ SIGNATURE _____