Northwest Gastroenterology
CLINIC & ENDOSCOPY CENTER

PATIENT INFORMATION

Patient Legal Name	DOB	Sex	SSN #
Address	City State, Zip		Home #
			Mobile #
Race: _____			Email:
Ethnicity: Would you describe yourself as Latino/ Hispanic? (circle) Yes No			
Occupation	Employer's Name		Employer's Phone
Pharmacy Name:	Pharmacy Loc:		Pharm Phn #
Referring Provider	Clinic Name		

EMERGENCY CONTACT INFORMATION

Name	Patient's relation to contact	Phone #

BILLING INFORMATION (If different from above)

Patient Name (If Minor, Responsible Party)	Patient's relation to contact	Social Security #

Date of Birth	Address	City, State, Zip	
Home Phone	Occupation	Employer	
Primary Insurance	ID Number	Group Number	
Subscriber Name	Date of Birth	Phone	
Secondary Insurance	ID Number	Group Number	
Subscriber Name	Date of Birth	Phone	
Is this visit the result of an injury? Yes No	Type of Injury On the Job:	Date of Injury	Time: Place

RELEASE: I authorize my insurance benefits to be paid to Northwest Gastroenterology Clinic, NGC Endoscopy Services and Complete Anesthesia Care. I understand I am financially responsible. I also understand that if my insurance is one that requires a referral, and one is not on file with Northwest Gastroenterology Clinic, NGC Endoscopy Services and Complete Anesthesia Care that I will be financially responsible for any and all charges incurred (including labs, X-rays and hospital charges).

I have reviewed the information and I have made the necessary corrections.

Patient or Legal Guardian Signature _____ Date_____