



PATIENT INFORMATION

Patient Name: _____
 Street Address: _____
 City: _____ State: _____ Zip Code: _____
 Home Phone: () _____ Work Phone: _____
 Cell Phone: () _____ E-mail Address: _____
 Social Security Number: _____ Date of Birth: _____
 Sex: (please check one box) M F Race: _____
 Marital Status: (please check one box) Married Single Divorced Widowed
 Primary Care Physician Name: _____ Phone Number () _____
 Referring Provider Name: _____ Phone Number () _____

OCCUPATION INFORMATION

Employer: _____ Occupation: _____
 Street Address: _____
 City: _____ State: _____ Zip Code: _____

EMERGENCY INFORMATION (Next of Kin)

Name: _____ Relationship: _____
 Home Phone: () _____ Work Phone: () _____
 Pharmacy: _____ Phone Number: _____
 City: _____ State: _____

INSURANCE INFORMATION

Primary Insurance Name: _____
 ID Number: _____ Group Number: _____
 Name of Insured: _____ Relationship to Insured: _____
 Insured SSN: _____ Insured Date of Birth: _____
 Secondary Insurance Name: _____
 ID Number: _____ Group Number: _____
 Name of Insured: _____ Relationship to Insured: _____
 Insured SSN: _____ Insured Date of Birth: _____

AUTHORIZATION FOR TREATMENT & ASSIGNMENT OF BENEFITS

This will authorize the filing of any insurance in force and the direct payment to Gastroenterology Associates of Tidewater of any amount due on my claim under the above stated policy. I understand that my insurance policy is a contract between me and my insurance company and that I am financially responsible to Gastroenterology Associates of Tidewater for non-payment of any fees not covered by insurance. I understand and agree to pay in full any balance due after an insurance payment or to make payment arrangements with Gastroenterology Associates of Tidewater. In consideration of service rendered, the undersigned patient, spouse, and/or responsible party agree that each will be jointly and severally liable and guarantee payment for any or all services rendered. It is further agreed that the undersigned patient, spouse, and/or responsible party agrees to pay all cost of collections including attorney's fees in the amount of 33-1/12 % plus court cost and any interest allowable by law, if incurred. Any unpaid balance will be subject to a finance charge of 1.5% per month (18% APR) commencing 60 days from the date of service. I hereby authorize the release of any medical information necessary to process claims.

Patient Signature: _____ Date Signed: _____

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 160 Kingsley Lane, Suite 200
 Norfolk, Virginia 23505
 (757) 889-6800
 Fax (757) 547-0145

Virginia Beach Office
 5701 Cleveland Street, Suite 100
 Virginia Beach, VA 23462
 (757) 547-0798
 Fax (757) 547-0145

Chesapeake Office
 112 Gainsborough Square, Suite 200
 Chesapeake, Virginia 23320
 (757) 547-0798
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