Alan J. Gamsey, MD, FACP, FACG, AGAF
Felix P. Tiongco, MD, FACP
Walid F. Makdisi, MD
Brian M. Sullivan, MD
Shoba Mendu, MD
Rene J. Rivera, MD
Jeremy P. Domanski, MD
Katelyne Hale, PA-C
Amber Stewart, PA-C
Ashton Dear-Huffman, PA-C

PATIENT INFORMATION

Patient Name: (First) ____ (M.I). ____ (Last) ____ : ____
Street Address: ____
City: ____ State: ____ Zip Code: ____
Home Phone: ( ) ____ Work Phone: ____
Cell Phone: ( ) ____ E-mail Address: ____ ☐ Web enabled
Social Security Number: ____ Date of Birth: ____
Sex: (please check one box) ☐ M ☐ F Ethnicity: ____ Language ____
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: ____