PACIFIC GASTROENTEROLOGY MEDICAL ASSOCIATES, INC.

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle: _____
Date of Birth: _____ Age: _____ Sex: ❑Male ❑Female
Street Address: _____
Apt #: _____ City: _____ State:_____ ZIP:_____
Mailing Address (if different): _____
Home Phone: _____ Work Phone: _____
Cellular Phone:_____ E-mail:_____
Employer: _____ Occupation: _____
Work Address: _____
City: _____ State _____ ZIP: _____
Social Security #: _____ Driver's License #: _____
Marital Status: ❑Single ❑Married ❑Divorced ❑Separated ❑Widowed
Race: ❑American Indian or Alaska Native ❑Asian ❑ Black or African American
❑Native Hawaiian or other Pacific Islander ❑ White ❑Other Race
Ethnicity: ❑ Hispanic or Latino ❑Non-Hispanic or Non-Latino

INSURANCE INFORMATION

Primary Insurance Co: _____
ID #: _____ Group #: _____ Co-pay Amount: $ _____
Subscriber Name: _____ Subscriber DOB: _____

Secondary Insurance Co: _____
ID #: _____ Group #: _____ Co-pay Amount: $ _____
Subscriber Name: Subscriber DOB:

GUARANTOR INFORMATION

Please complete this section if someone other than the patient is guarantor of payment.
Guarantor's Name (❑spouse, ❑parent or ❑guardian): _____
Street Address: _____
Apt #: _____ City: _____ State:_____ ZIP:_____
Home Phone: _____ Work Phone: _____
Employer: _____ Occupation: _____
Work Address: _____
City: _____ State _____ ZIP: _____
Social Security #: Driver's License #:

OTHER IMPORTANT INFORMATION

Contacts:
Spouse: Name _____ Cell Phone _____ Work Phone _____
Emergency Contact: Person to contact in an emergency (someone not living with you):
Last Name _____ First Name _____ Relationship _____
Home Phone # _____ Cell Phone #_____
Pharmacy: Name & City _____ Phone _____
Referring MD: _____**Primary Care Physician:** _____
How did you hear about us? ❑Referred by Physician (Name: _____)
❑I am existing Patient ❑Referred by Friend or Family Member (Name:_____)
❑Listed in Insurance Plan Roster ❑Internet : Name of the website: _____
❑Phone Book ❑Other (please specify): _____

Signature of Patient/Guardian:_____ Date: _____