CONNECTICUT GASTROENTEROLOGY ASSOCIATES,P.C.

www.gastroct.com

Patient Name (First, Middle, Last)	SEX □ Female □ Male	Maritul Status □ S □ M □ D □ W
Social Security#	Date of Birth	

Answers to Questions Below ARE Required by the Federal Government American Recovery & Reinvestment Act of 2009

Race	Ethnicity	Language
☐ Caucasian	☐ Hispanic/Latino	☐ English
☐ Black	☐ Not Hispanic/Latino	☐ Spanish
☐ Asian	☐ Caucasian	☐ French
☐ American Indian/Native Alaskan	☐ Other	☐ Polish
☐ Native Hawaiian/Pacific Islander	☐ Unknown	☐ Vietnamese
☐ Other Race		☐ Sign
☐ Unknown		☐ Other

Email Address

Employment Status

☐ Employed ☐Unemployed ☐ Retired ☐ Part-Time Student

☐ Self-Employed ☐ Disabled ☐ Full-Time Student

Mailing Address City State

Home # Mobile # Work # & Extension

Employer Employer Address City State

Referring Physician Name and Address

Primary Physician Name and Address

Pharmacy Name and Address

Primary Insurance Plan Name Group # Insurance ID#

Effective Date Visit Copay $ Amount Subscriber: □ Patient □ Parent □ Spouse □ Other

Subscriber Name DOB:

Social Security # Employer

Secondary/Supplemental Insurance Plan Name Group # Insurance ID#

Effective Date Visit Copay $ Amount Subscriber: □ Patient □ Parent □ Spouse □ Other

Subscriber Name DOB:

Social Security # Employer

Who should we contact in case of EMERGENCY?

Name Phone # Relationship to Patient:

I hereby authorize direct payment of medical/surgical benefits to Connecticut Gastroenterology Associates, P.C. for services rendered by our providers. I understand that I am financially responsible for any balance not covered by my insurance. I certify that the information given by me in applying for payment is correct. I hereby authorize the release of any and all medical or other information for the purpose of processing my insurance claims.
A photocopy of my signature is as valid as the original.

Signature of Patient / Guarantor _____ **Date**_____