Please fill out **COMPLETELY**, and bring with you for your appointment.
DO NOT MAIL!!

Gastroenterology Associates, Inc.

North East Ohio Endoscopy Center, Inc.

UPDATE YEARLY

PATIENT INFORMATION

USE INK ONLY.

Date: _____

Patient: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone No.: ( ) _____ Referred by: _____

Cell Phone No.: ( ) _____

Social Security No.: _____ Sex *(please circle)*: M F Race: _____

Date of Birth: _____ Marital Status *(please circle)*: Married Widowed Divorced Single

---

Patient's Employer: _____

Is it OK to contact you at your employment? ❑ yes ❑ no Business Phone No.: ( ) _____

Spouse's Full Name: _____ Date of Birth: _____

Primary Insurance: _____
(name of insurance co.) *(address)*

Contract No./I.D. Number _____ Group No.: _____ Copay: _____

Policy Holder: _____ Relationship: _____ DOB: _____

Secondary Insurance: _____
(address)

Contract No./I.D. Number _____ Group No.: _____

Policy Holder: _____ Relationship: _____

Family Physician: _____

Emergency Contact:

Name: _____ Phone No.: ( ) _____

If you would like to receive an invitation to join our secure patient portal, please provide your email address:

_____

Please See Other Side
⇩

Gastroenterology Associates, Inc.
North East Ohio Endoscopy Center, Inc.

4665 Belpar St., N.W. • P.O. Box 36329 • Canton, Ohio 44735
(330) 493-1480

PLEASE SIGN WHERE MARKED!!!

MEDICARE PATIENTS: Please sign statement below:

I request that payment of authorized Medicare benefits be made on my behalf to Gastroenterology Assoc./ **North East Ohio** Endoscopy Center, Inc. for any services furnished me by one of the physicians. I authorize release to the Health Care Financing Administration and its agents any medical information about me needed to determine these benefits or benefits payable for related services.

X _____ X _____

PATIENT SIGNATURE DATE

NON-MEDICARE PATIENTS: Please sign statement below:

I UNDERSTAND THAT I AM RESPONSIBLE FOR FULL PAYMENT OF BY BILL, IN A TIMELY MANNER.

I authorize the release of any medical information necessary to process this claim:

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and other health plans to Gastroenterology Assoc., Inc./ **North East Ohio Endoscopy Center, Inc.**

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

X _____ X _____

PATIENT/RESPONSIBLE PARTY SIGNATURE DATE