DIGESTIVE HEALTH ASSOCIATES of Cheyenne

Today's Date: _________________

Patient Name____

Mailing Address ________________________________ City ________________ State _______ Zip _________

Telephone: Home _____________________ Work _____________________ Cell ________________________

As a service to our clients, we provide a courtesy appointment reminder call that may be placed using a prerecorded message. By providing your cell phone number, you consent to receiving such calls at this number.

Social Security # _____________________________ Birth date ___________________________

Marital Status: (Circle one) Single Married Divorced Widowed

Employer ____ Telephone __________________________________

Authorized Parties to Speak with Regarding your Billing: Self Other_________________________________

<u>Insurance Information</u>:

Primary Insurance ____

Name of Subscriber ____________________ Birth date _____________ Social Security#_________________

Secondary Insurance ____

Name of Subscriber ______________________Birth date_____________Social Security#__________________

EMERGENCY CONTACT INFORMATION:

Name __________________________ Relationship _______________ Telephone ________________________

I hereby authorize medical treatment of the above named person and agree to be financially responsible for all charges for such treatment, including costs of collection and legal fees (if applicable.) I hereby assign payments to Internal Medicine Group. I authorize Internal Medicine Group to release any medical information necessary to process my insurance claims. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

Patient /Parent/ Guardian Signature: _____________________________________ Date: __________________

Acknowledgement of Receipt of Notice of Privacy Practices

I, ____, have received a copy of Digestive Health Associates of Cheyenne.

Signature of Patient ____ Date______________________________