ISLAND
GASTROENTEROLOGY
CONSULTANTS, P.C.

1111 Montauk Highway, Suite 3-1
West Islip, NY 11795
TEL 631-669-1171 FAX 631-669-1912

PATIENT DEMOGRAPHICS

Name: _____ _____ _____ SS#: _____
Last First M

Address: _____ _____ _____ _____
Street City State Zip

Phone: _____ Work: _____ Cell: _____

Birth Date: _____ Age: _____ Sex: ____ Marital Status: S ☐ M ☐ W ☐ D ☐

Primary Language Spoken: _____ Ethnicity/Race: _____

Emergency Contact Person: _____ Emergency Contact Phone: _____

Patient's Employer: _____ Occupation: _____

Employers Address: _____ _____ _____ _____
Street City State Zip

Primary Care Physician: _____ Phone Number: _____

Allergies: _____

Please be advised that we will submit to your primary and secondary insurances. Any remaining balances after receipt of explanation of benefits from your primary and/or secondary insurance carrier will be billed to you.

INSURANCE INFORMATION

Primary Insurance Co: _____ Phone Number: _____

Identification Number: _____ Group Number: _____

Name of Policy Holder: _____ DOB of Policy Holder: _____

Patient Relationship: Self ☐ Spouse ☐ Child ☐

Secondary Insurance Co: _____ Policy Holder: _____

Identification Number: _____ Group Number: _____

I request that payment of authorized Medicare/other insurance company benefits be made on my behalf to Island Gastroenterology Consultants, P.C. for any services furnished to me by that third party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.
In the event my insurance company pays me directly, I will forward payment immediately to Island Gastroenterology Consultants P.C. Along with the explanation of benefits from my insurance company. If my insurance company fails to make payment for my services, I agree to be financially responsible.
I authorize any holder of any medical or other information about me to release to the Social Security Administration and Health Care Administration or its intermediaries or carriers, information needed for this or a related Medicare/other insurance company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. I understand that it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment (Section 112.86 of the Social Security Act and 31 U.S.C. 3801-3912. provides penalties for withholding this information).

Signature: _____ Date: _____