

HAMILTON GASTROENTEROLOGY GROUP, P.C.

2107 KLOCKNER ROAD, BLDG 6
HAMILTON, NJ 08690
(609)586-1319

HAMILTON ENDOSCOPY &

SURGERY CENTER

1235 WHITEHORSE-MCVL ROAD
BLDG C, SUITE 310
HAMILTON, NJ 08619
(609)581-6610

PATIENT INFORMATION:

Name: _____ DOB: _____
Last First MI

Address: _____
Street City State Zip

Home Phone: _____ Work Phone: _____

Acceptable to leave message at the following: Home [] Work [] Other [] _____

SS# _____ Sex: M [] F [] Marital Status: S [] M [] W [] D [] Other []

Emergency Contact Person: _____ Phone #: _____

Patient's Employer: _____ Occupation: _____

Employer's Address: _____
Street City State Zip

All professional services are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. Please be advised that we will submit to your primary and secondary insurance. Any remaining balance after receipt of explanation of benefits from your primary and/or secondary insurance carrier will be billed to you.

PRIMARY PHYSICIAN:

Name: _____ Phone #: _____

Address: _____
Street City State Zip

PATIENT'S RIGHTS AND PRIVACY PRACTICES:

_____ (Please Initial) I have been made aware of the HIPAA Regulations and Patient Rights Policies.

PHARMACY:

Name: _____ Address: _____

Phone #: _____

ALLERGIES: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT:

Name of Primary Policy Holder: _____

Relationship: Self [] Spouse [] Parent [] Other [] DOB: _____ SS#: _____

Primary Insurance Policy: _____ (Policy Holder)

Secondary Insurance Policy (if applicable): _____

I request that payment of authorized Medicare/other insurance benefits be made either to me on my behalf or to Hamilton Gastroenterology Group, P.C./Hamilton Endoscopy and Surgery Center for any services furnished me by that third party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to be released to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers and information needed for this or a related Medicare claim/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 to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information).

Signature of Responsible Party

Date