BRANDYWINE GASTROENTEROLOGY ASSOCIATES, LTD.

Please Print

PATIENT INFORMATION

Date: ________________________ Updated _______________

Last Name: _________________________________ Patient's SS#: _________________________________

First Name: __________________ Middle ________ Birth date: _______________ Age: _____ M/F

Street: ______________________________________ Marital Status: Single Married Divorced Widow Child

City: ____ Cell Phone: ___________________________________

State, Zip Code: ______________________________ Patient's Employer: _____________________________

Phone: _____________________________________ Employer Address: ______________________________

Email Address: ______________________________ ____

Spouse's Name: _____________________________ Patient Work Phone: ___________________________

Spouse's Employer: ___________________________ Spouse Work Phone:___________________________

Spouse's Employer Address: ____

If insurance coverage is in spouse/parents name provide name, birth date and social security of insurance holder:

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Referring/Family Doctor and Phone Number: ____

Emergency Contact (**other than home**) Name: ____

Relationship:__________________________________ Phone Number: _______________________________

Pharmacy and Phone Number: ____

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I hereby authorize Brandywine Gastroenterology Associates, Ltd. to furnish information to my insurance carrier concerning my illness and treatments and I hereby assign to the physicians all payments for medical services rendered to my dependents or myself. A copy of this can be considered as an original for insurance purposes. I further understand that any balances not paid by my insurance company are due and payable upon receipt of statement. If married, both parties are equally responsible for any debts that may occur. In case of a child, any debt that occurs is the responsibility of both parents unless court document is presented to the contrary. I also understand that this office may add collection and /or lawyer fees to any unpaid balances should there be a need to pursue the collection process. I also authorize the release of my medical records to other physicians needed for my treatment.

Date: _____________ Signature: ____