

# PATIENT INFORMATION SHEET

Patient Name: \_\_\_\_\_ Acct #: \_\_\_\_\_  
Last First Middle Initial

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ SSN: \_\_\_\_\_

Gender:  Male  Female Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed

Occupation Status:  Unemployed  Employed  Retired  Disabled

Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Who referred you? \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Have you seen a provider at Valley Gastro before?  Yes  No

Primary Insurance: \_\_\_\_\_

Policy Holder Name : \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_  
(If not yourself)

Policy Holder's Relationship to Patient:  Spouse  Parent  Other: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Policy Holder Name : \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_  
(If not yourself)

Policy Holder's Relationship to Patient:  Spouse  Parent  Other: \_\_\_\_\_

Which Pharmacy do you use? \_\_\_\_\_ City? \_\_\_\_\_

Your copay and deductibles are due at the time of service. By signing this, you agree to be responsible for any charges that your insurance company does not pay after assignment is accepted. You are giving us authorization to bill Medicare and/or any other insurance company that you are covered by. This authorization applies to all occasions of service until it is revoked by the patient or an authorized representative in writing.

\_\_\_\_\_  
Signed by patient or authorized representative

\_\_\_\_\_  
Date