METROPOLITAN GASTROENTEROLOGY, P.C.

23-25 31st Street Suite700
Astoria, NY 11105
Phone: 718-932-6000

Date: ____________________

Name:____ **Date of Birth**:____________________
Last First M.I MM/DD/YY

Address:____ **Email**:______________________________

City:______________________ **State**:________ **Zip Code**:______________ **Social Security No**.:______________________

Married☐ Widowed☐ Single☐
Separated☐ Divorced☐
Other:____________

Preferred Language: English☐
Spanish☐ Greek☐ Italian☐
Other:______________________

Home Phone:________________________________
Work Phone:________________________________
Cell Phone:________________________________

Employer/Occupation: ____

Drug/food Allergy: ____

Smoker? Yes☐ No☐ **Sex**: M☐ F☐ **Age**: ________

Ethnicity: Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient Decline ☐ Unknown☐

Race: White ☐ American Indian ☐ Alaskan Native ☐ Asian ☐ Native American ☐ Patient declined to provide ☐
Black ☐ African American ☐ Native Hawaiian ☐ Other Pacific Island ☐ Unknown ☐ Other ☐________________

In case of an emergency who should be notified? ____________________________________ **Phone**:______________________

Primary Care Physician:____ **Referred by**______________________________

Additional reports to be sent to ____

PRIMARY INSURANCE INFORMATION

Person Responsible Account:____ **Birthdate**:____________________
Relation To Patient:____ **Social Security No.**:____________________
Insurance Company:__________________ **Policy No.**:________________ **Subscriber**:______________________________

SECONDARY INSURANCE INFORMATION

Person Responsible Account:____ **Birthdate**:____________________
Relation To Patient:____ **Social Security No.**:____________________
Insurance Company:__________________ **Policy No.**:________________ **Subscriber**:______________________________

I understand that I am financially responsible for all charges for services to me, including the balance remaining after payment of possible insurance benefits.

Signature of Patient:____________________________________ Date:______________

ASSIGNMENT OF BENEFITS: I authorize payment of medical benefits to myself or the names provided for professional service rendered.

Signature of Patient:____________________________________ Date:______________

Release of Information: I authorize the release of any medical information necessary to process this claim or as required by law.

Signature of Patient:____________________________________ Date:______________