UPSTATE GASTROENTEROLOGY ASSOCIATES, PC
2200 BURDETT AVENUE – SUITE 205
TROY, NEW YORK 12180

NAME: _____
Last *First* *M.I.*

ADDRESS: _____
Number & Street *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home Phone: _____ Cell Phone: _____

Social Security #: _____DOB: _____ Email: _____

Gender: M_____ F_____ Marital Status: _____ Spouse's Name: _____

Patient Employer: _____ Work Phone: _____

Primary Insurance: _____

Secondary Insurance: _____

Other than Self:
Person Financially Responsible: _____ DOB: _____

Address: _____
Number & Street, Apt #, PO Box, RD or RR *City/Town* *State* *Zip Code*

Referring physician: _____ Phone: _____

Primary physician: _____ Phone: _____

Pharmacy: _____ Phone: _____

Emergency Contact: _____

Relationship: _____

Home Phone; _____ Cell Phone: _____Work Phone: _____

Assignment of benefits/Release of records

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance and any other health plans to Upstate Gastroenterology Associates, PC. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release any information necessary to secure said benefits.
I hereby authorize Upstate Gastroenterology Associates, P.C. to release any information, including the diagnosis and records of any treatment rendered to myself, or to my son/daughter, to my referring physician or to any other physician from whom I seek medical treatment. Additionally, I hereby authorize any other physician who has rendered services to me to release to Upstate Gastroenterology Associates, PC. such information as they shall request to assist in my medical treatment.

SIGNATURE: _____ DATE: _____