Monterey Bay G.I. Consultants Medical Group Inc.
Monterey Bay Endoscopy Center LLC

(Please use black ink only)

Patient Name: _____ Date: _____
First M.I. Last

Mailing Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____ Work Phone: _____ E-Mail: _____

Sex: M / F Marital Status: _____ DOB: _____ Driver's License # _____ SSN# _____

Employer: _____ Occupation: _____
Name Address Phone

Primary Care Physician: _____ Referring Physician: _____
Name / Address (If other than the primary physician)

Emergency Contact: _____
Name Address Phone

Ethnicity (circle one): E1 Hispanic/Latino or E2 Non-Hispanic/Non Latino

Race (circle one): R1 American Indian R2 Asian R3 Black/African American R4 Hawaiian/Pacific Islander R5 White R9 Other

INSURANCE INFORMATION

Please complete the following information below and present your insurance card(s) to the receptionist.

Primary Insurance: _____ Insured's Name: _____ Insured's SSN#: _____
Insured's DOB: _____ Relationship to Insured (circle one): Self Spouse Child
Insured's Employer Name: _____
Name Address Phone Number

Secondary Insurance: _____ Insured's Name: _____ Insured's SSN#: _____
Insured's DOB: _____ Relationship to Insured (circle one): Self Spouse Child
Insured's Employer Name: _____
Name Address Phone Number

It is a requirement of our insurance contracts to collect co-payments at the time of service. It is the policy of this office to collect co-payments and deductibles at the time of service. Physician and facility charges will be billed to you unless insurance information is provided to our office before the time of service. You are responsible to contact your insurance prior to services to determine if an authorization is requested. Failure to obtain authorization will result in you being responsible for the services provided.

I consent to treatment for the care of the above patient. I authorize the release of all medical records to the referring and family physicians and to insurance carriers as needed to process a claim. I allow fax transmittal of medical records if necessary. I request insurance payments of medical benefits be made directly to the physicians provider and/or the facility provider. I understand that I am financially responsible for all charges and that I will be expected to pay if my insurance has not paid within 90 days from the date of service.

Patient's Signature: _____ Date: _____ Reviewed by: _____