Advanced Gastroenterology Group

Ramon F. Ledon, M.D.
Patrick G. Tempera, M.D.
Rajesh Dhirmalani, D.O.
Kunal Grover, M.D.
Ellen C. Ebert, M.D.
Michael J. Viksjo, M.D.

PATIENT INFORMATION

Last Name:	First Name:	Middle Name:

Sex: ❑ M ❑F	Social Security Number:	Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed	Date of Birth:

Race: ❑ African American ❑ American Indian ❑ Asian ❑ Caucasian ❑ Hispanic ❑ Pacific Islander ❑ Other _____	Ethnic Group/Nationality:	Primary Language: ❑ English ❑ Español ❑ Português ❑ Other: _____

Home Address: Apt:	City:	State:	Zip:

Home Phone:	Work Phone:	Cell Phone:

Primary Doctor & telephone number:	Preferred Pharmacy Name, Location, and Number:

Cardiologist Name & phone number:	Who referred you to our practice?

What is your email address:

INSURANCE INFORMATION

Primary Insurance Company:	Secondary Insurance Company:

Under whose name is your insurance? ❑ Self ❑ Other _____	What is their date of birth?

What is your relationship?	What is their Social Security Number?

PATIENT CONFIDENTIALITY

Patient confidentiality is of great concern to our office. Please indicate below with whom our office may speak or leave a message with regarding your health, medication, test results, etc.		
Name:	Relationship:	Phone Number:

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Name:	Relationship:	Phone Number:

May we call you at work? ❑ **Yes** ❑ **No**	**May we leave a voicemail?** ❑ **Yes** ❑ **No**

P A T I E N T A G R E E M E N T

Should inaccurate or omitted insurance information be supplied causing a reduction or non-payment of benefits, the obligation of payment will be transferred to the responsible party. I hereby authorize the release of any medical information for the processing of insurance. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled to Advanced Gastroenterology Group. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Patient Signature: _____ **Date:** _____