LONG ISLAND DIGESTIVE DISEASE CONSULTANTS

# PATIENT INFORMATION

DATE _____

NAME _____

[LAST] [FIRST} [MIDDLE INITIAL]

ADDRESS _____ CITY _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

MARITAL STATUS S _____ M _____ D _____ W _____ BIRTHDATE _____

SOCIAL SECURITY # _____ PRIMARY CARE PHYSICIAN _____

EMPLOYER NAME _____ OCCUPATION _____

WORK ADDRESS _____ CITY _____ ZIP _____

NAME OF SPOUSE _____

[LAST] [FIRST] [MIDDLE INITIAL]

SOCIAL SECURITY # _____ BIRTHDATE _____

SPOUSE'S EMPLOYER _____ OCCUPATION _____

WORK ADDRESS _____ CITY _____ ZIP _____

IN CASE OF EMERGENCY NOTIFY _____

TELEPHONE _____ RELATIONSHIP _____

REFERRING PHYSICIAN _____ EMAIL ADDRESS _____

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PRIMARY INSURED _____

INSURANCE COMPANY _____

ID # _____ GROUP # _____ COVERAGE CODE _____

ADDRESS FOR CLAIM SUBMISSION _____

_____

SECONDARY INSURED _____

INSURANCE COMPANY _____

ID # _____ GROUP # _____ COVERAGE CODE _____

ADDRESS FOR CLAIM SUBMISSION _____

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**ASSIGNMENT OF BENEFITS**

I authorize payment of medical benefits to myself or the named provider for professional services rendered.

Signed _____ Date _____

(Subscriber)

**RELEASE OF INFORMATION**

I authorize the release of any medical information necessary to process this claim.

Signed _____ Date _____

(Patient, or parent if Minor)