Grayson
Digestive Disease Consultants PLLC.

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Today's date:								
PATIENT INFORMATION								
Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one)			
					Single / Mar / Div / Sep / Wid			
Is this your legal name?		Former name?	Social Security No:		Birth date:	Age:	Sex:	
❑ Yes	❑ No				/ /		❑ M	❑ F
Street address:			Home phone no:		Cell phone No:			
			( )		( )			
P.O. box:	City:		State:		ZIP Code:			
Occupation:	Race:				Primary language:			
Email:	Pharmacy:				Pharmacy phone #			
Referring Physician:								
Primary Care Physician:								
INSURANCE INFORMATION								
(**Please give your insurance card(s) and driver's license to the receptionist**.)								
Person responsible for bill:								
Relationship:	Birth date:	Address (if different):			Home phone no.:			
	/ /				( )			
Primary Insurance	Subscriber's name:				Group no.:	Member ID:		
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other				
Secondary Insurance	Subscriber's name:				Group no:	Member ID :		
IN CASE OF EMERGENCY								
Name of local friend or relative:	Relationship to patient:				Home phone no.:	Work phone no.:		
					( )	( )		
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize *Grayson Digestive Disease Consultants* or insurance company to release any information required to process my claims.								
Patient/Guardian signature:					*Date:*			