## BROOKHAVEN GASTROENTEROLOGY ASSOCIATES, P.C. PATIENT REGISTRATION & INFORMATION FORM

Patient Name			<b>_</b> M	□F	Date of Birth
Marital Status	☐ Married	Divorced	■ Widowed	SS	#
Address		_ City	State _		Zip
					Zip
Emergency Contact			Phone		)
	PRIM	MARY INSURAN	ICE CARRIER		
					GRP#
* If you are not the subscriber please give	name, DOB and SS # of s	subscriber			
Subscriber Employer			Phone	. (	)
Address					
SECONDARY INSURANCE					
					GRP#
Subscriber		DOB	SS#		
Do you have a Health Care Prox	y? 🔲 Yes	☐ No If Ye	s, please provide a c	opy. If N	No, forms are available upon request.
Pharmacy		*	Phon	e <u>(</u>	)
Address					
Primary Care Physician			Phon	e <u>(</u>	)
I authorize the release of all health care information by Brookhaven Gastroenterology Associates and the payment of medical benefits to the attending physician(s) for services rendered. I understand that I am responsible for any and all balances due to Brookhaven Gastroenterology Associates. I understand that the release of my health care information is necessary for treatment and payment for services. I understand that I have the right to restrict the release of my health care information; however, by doing so, I understand that my insurance may deny payment. If I choose to restrict the release of my health care information, I may be responsible to pay at the time of services, including but not limited to, any health care services that may derive from the services received. This authorization is valid for three years from the date of this registration.					
By my signature below, I hereby acknowledge receipt of this Notice of Privacy Practices, and I acknowledge that the Practice will use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting health care operations; That may include contacting me at the information I provided above. I understand that a message may be left on the telephone number provided and I may not be the only recipient of the message.					
I have also been advised of my rights t	to obtain access to and o	control my Protected He	alth Information.		
I have read the above information and Gastroenterology Associates.	agree to have my Health	n care information relea	sed for purposes of treat	ment and	payment of services to Brookhaven
Patient Signature					Date
How were you referred to our pr					ment. What paper?
	□ We	heite  Hosn	ital		Other