

**Patient Registration**

**Middlesex Gastroenterology Associates**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Sex (Please Circle): M F Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Street: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email Address: \_\_\_\_\_

Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Primary Language: \_\_\_\_\_

**Please check the phone number we should call first:**

**Preferred Communication:**

- Home Phone: \_\_\_\_\_
- Cell Phone: \_\_\_\_\_
- Business Phone: \_\_\_\_\_
- Other: \_\_\_\_\_

- Home Phone
- Patient Portal
- Email
- Business Phone
- Cell Phone

Employer's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_ Who Referred You: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_ Location: \_\_\_\_\_

**Emergency Contact Information**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Preferred Phone: \_\_\_\_\_ Alternate Number: \_\_\_\_\_

**Alternate Emergency Contact — Person not living with you to notify in case of an emergency:**

Name: \_\_\_\_\_ Preferred Phone: \_\_\_\_\_

**Primary Insurance:** \_\_\_\_\_ Employer: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Their Date of Birth: \_\_\_\_\_

Relationship: \_\_\_\_\_ Policy ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ Employer: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Their Date of Birth: \_\_\_\_\_

Relationship: \_\_\_\_\_ Policy ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

**Patient's Insurance Authorization** (must be filled out and signed in order for us to send a claim to your insurance)

I request that payment of authorized benefits be made on my behalf to Middlesex Gastroenterology Associates for any services furnished to me. I give permission to Middlesex Gastroenterology Associates to release medical information pertaining to claims to my insurance carrier for services provided by them.

Name (Please Print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_