Patient Demographic Form

Please complete and return this form to us before the date of your scheduled appointment.

PATIENT DATA FORM
MUST BE COMPLETED IN FULL

Last Name:_____ First Name:_____ Middle Name:_____ Suffix: ____

Sex: M / F Date of Birth: _____ /_____ /_____ Social Security Number: _____-_____-_____

Street Address:_____ Suite: _____ City: _____ Zip: _____

Phone (_____)_____-_____ Work (_____)_____-_____ Mobile (_____)_____-_____

Email Address: _____@_____

The best way to contact me is on my: ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Mail ☐ Email / Patient Portal

Can you receive texts for appointment reminders? ☐ Yes ☐ No If yes, the number we can text: _____

THE GOVERNMENT REQUIRES US TO COLLECT THE FOLLOWING INFORMATION FROM ALL OF OUR PATIENTS

Language: ☐English ☐Spanish ☐Farsi ☐Russian ☐Chinese ☐French ☐Japanese ☐ Armenian ☐Other: _____

Race: ☐ American Indian ☐Asian ☐African American ☐ White ☐ Native Hawaiian/Other Pacific Islander ☐ Other: _____ ☐ Decline to state

Ethnicity: ☐Hispanic or Latino/Spanish ☐Not Hispanic or Latino ☐Decline to state

Marital Status: ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced ☐Partner

How did you hear about us?

☐Web ☐Ad ☐Primary Care Physician ☐Other Physician ☐Friend/Family ☐Hospital ☐Insurance Company ☐Other: _____

GUARDIAN INFORMATION

Guardian Last Name:_____ Guardian First Name:_____ Guardian Middle Name: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name:_____ Relationship:☐Spouse ☐Parent ☐Friend ☐Child ☐Sibling ☐Cousin ☐Other: _____

Emergency Contact Phone:(_____)_____-_____ Emergency Contact Mobile:(_____)_____-_____

EMPLOYER INFORMATION

Employer Name:_____Employer Address:_____ Suite: _____ Zip: _____

Phone (_____)_____-_____ Fax (_____) _____-_____Occupation: _____

REFERRING DOCTOR INFORMATION

Provider Last Name:_____ Provider First Name:_____

Primary Care? Y / N If no, who is your primary care provider (PCP)? _____

Provider Address:_____ Suite: _____ Zip: _____

Phone (_____)_____-_____ Fax (_____) _____-_____ Specialty: _____

GUARANTOR INFORMATION

Please list the information of the individual financially responsible for the patient.

Relationship to Patient: ☐Self ☐Spouse ☐Parent ☐Friend ☐Child ☐Sibling ☐Cousin ☐Other: _____

Guarantor Last Name:_____ Guarantor First Name:_____ Guarantor Middle Name: _____

Guarantor Date of Birth: ____ / ____ / _____

Guarantor Address:_____ Suite: _____ City: _____ Zip: _____

Optional Guarantor Information

Guarantor SSN: _____-_____-_____ Guarantor Phone: (_____)_____-_____

Guarantor Email: _____@_____

Patient Full Name: _____

INSURANCE INFORMATION

Insurance Policy Name: _____ Policy Type: ☐ HMO ☐ PPO

Patient's Relationship to Policy Holder: _____ Patient ID: _____ Policy No.:_____

Policy Holder's Last Name _____ Policy Holder's First Name _____

Policy Holder's Date of Birth: ____ / ____ / _____ Policy Holder's Sex: M / F

Secondary Policy – Only if you have a second policy/plan.

Insurance Policy Name: _____ Policy Type: ☐ HMO ☐ PPO

Patient's Relationship to Policy Holder: _____ Patient ID: _____ Policy No.:_____

Policy Holder's Last Name _____ Policy Holder's First Name _____

Policy Holder's Date of Birth: ____ / ____ / _____ Policy Holder's Sex: M / F

Tertiary Policy – Only if you have a third policy/plan.

Insurance Policy Name: _____ Policy Type: ☐ HMO ☐ PPO

Patient's Relationship to Policy Holder: _____ Patient ID: _____ Policy No.:_____

Policy Holder's Last Name _____ Policy Holder's First Name _____

Policy Holder's Date of Birth: ____ / ____ / _____ Policy Holder's Sex: M / F

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY

By signing below, I certify that the above information is correct to the best of my knowledge. I consent to be treated by the staff and providers of Southern California Gastroenterology Associates. I authorize payment of medical benefits to Southern California Gastroenterology Associates, and authorize them to release any medical information necessary to process claims. I understand that I am responsible for co-payments, deductibles, co-insurance and non-covered services.

I authorize the doctor to obtain medical records, demographic and insurance information from prior hospitals, laboratories or medical groups who have provided health care services if this information is needed now in order for the doctor to provide medical services.

By signing below, I also consent to receiving pre-recorded calls from Southern California Gastroenterology Associates for reminders about my health, upcoming appointments and information on other services at the numbers mentioned on the first page of this form, including my wireless number, if applicable. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

Patient / Guarantor Signature* _____ Date: _____

**If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.*