GANJ
GASTROENTEROLOGY
ASSOCIATES OF NEW JERSEY

Date: _____

PATIENT REGISTRATION INFORMATION

PLEASE PRINT

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr. _____ Previous Name: _____
CHOOSE ONE↑ LAST NAME FIRST NAME MI (E.G., MAIDEN NAME)

Address: _____
STREET ADDRESS CITY STATE ZIP

Phone – Home _____ Cell: _____ Work: _____ ext _____

Ethnicity: _____ Race: _____

Primary Care Provider: _____ Referring Provider _____
NAME AND CITY (if different than PCP) NAME AND CITY

Patient date of birth: _____ ☐ M ☐ F ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated SS #: _____ –____–____

Patient employed by: _____

Business Address: _____
☐ Full time ☐ Part time ☐ Not employed ☐ Self employed ☐ Retired ☐ Active Military Duty ☐ Full time student ☐ Part time student

Responsible Party: _____ Phone: _____
(STATEMENTS WILL BE ADDRESSED TO RESPONSIBLE PARTY) LAST NAME FIRST NAME MI

Address of Responsible Party: _____ Relationship: _____
STREET ADDRESS CITY STATE ZIP

Emergency Contact: _____ Phone: _____
LAST NAME FIRST NAME MI

Address of Emerg. Contact: _____ Relationship: _____
STREET ADDRESS CITY STATE ZIP

Name of Primary Insurance _____ Subscriber ID # _____

Name of Insured: _____ Relationship: _____ Group #: _____

Policy Holder DOB: _____

Name of Secondary Insurance (if any) _____ Subscriber ID # _____

Name of Insured: _____ Relationship: _____ Group #: _____

Patient's e-mail address: _____

Your local pharmacy name: _____ City: _____ Phone _____

Mail Order pharmacy name: _____ City/State: _____ Phone _____

Preferred Language: _____ Translator Required? ❑ Y ❑ N

RELEASE OF PERSONAL INFORMATION TO THE PATIENT'S DESIGNEES

I authorize medical staff members of this practice to discuss my medical history, diagnosis, treatment and prognosis with those listed below.

Name	Phone Number	Relationship

Patient's home phone: ☐ OK to leave message with detailed information ☐ Do not leave details; leave message with callback number only

How did you learn of this practice? _____

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependants. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or my dependants and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, _____ herby authorize _____
(name of insured) (name of insurance company)

to pay and hereby assign directly to *Practice Name* all benefits, if any, otherwise payable to me for the services as described on the attached forms. I understand that I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to *Practice Name*, PA will be credited to my account, in accordance with the above said

_____ _____
(authorized signature of subscriber) (date)