LONG ISLAND
DIGESTIVE DISEASE
CONSULTANTS

PATIENT INFORMATION

DATE _____

NAME _____
[LAST] [FIRST} [MIDDLE INITIAL]

ADDRESS _____ CITY _____ ZIP _____
HOME TELEPHONE _____ WORK TELEPHONE _____
MARITAL STATUS S _____ M _____ D _____ W _____ BIRTHDATE _____
SOCIAL SECURITY # _____ PRIMARY CARE PHYSICIAN _____
EMPLOYER NAME _____ OCCUPATION _____
WORK ADDRESS _____ CITY _____ ZIP _____
NAME OF SPOUSE _____
[LAST] [FIRST] [MIDDLE INITIAL]
SOCIAL SECURITY # _____ BIRTHDATE _____
SPOUSE'S EMPLOYER _____ OCCUPATION _____
WORK ADDRESS _____ CITY _____ ZIP _____
IN CASE OF EMERGENCY NOTIFY _____
TELEPHONE _____ RELATIONSHIP _____
REFERRING PHYSICIAN _____ EMAIL ADDRESS _____

PRIMARY INSURED _____
INSURANCE COMPANY _____
ID # _____ GROUP # _____ COVERAGE CODE _____
ADDRESS FOR CLAIM SUBMISSION _____
_____

SECONDARY INSURED _____
INSURANCE COMPANY _____
ID # _____ GROUP # _____ COVERAGE CODE _____
ADDRESS FOR CLAIM SUBMISSION _____
_____

ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to myself or the named provider for professional services rendered.

Signed _____ Date _____
(Subscriber)

RELEASE OF INFORMATION

I authorize the release of any medical information necessary to process this claim.

Signed _____ Date _____
(Patient, or parent if Minor)