

**CONFIDENTIAL PATIENT INFORMATION**

Account \_\_\_\_\_ MD \_\_\_\_\_ Date of Service \_\_\_\_\_

Legal Last Name \_\_\_\_\_ Legal First Name \_\_\_\_\_ Initial \_\_\_\_\_

Address \_\_\_\_\_ Zip Code \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Home Telephone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Preferred Name \_\_\_\_\_

Social Security # \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Referring Physician \_\_\_\_\_  
First Name Last Name First Name Last Name

Employer \_\_\_\_\_ Work Telephone \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Work Telephone \_\_\_\_\_

Employer \_\_\_\_\_

(Please bring insurance cards to copy for our records).

Primary Insurance \_\_\_\_\_ Name of Policy Holder \_\_\_\_\_

Group# \_\_\_\_\_ Policy # \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Policy Holders Birth Date \_\_\_\_\_ Policy Effective Date \_\_\_\_\_

Secondary Insurance \_\_\_\_\_ Name of Policy Holder \_\_\_\_\_

Group# \_\_\_\_\_ Policy # \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Policy Holders Birth Date \_\_\_\_\_ Policy Effective Date \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Telephone \_\_\_\_\_ Circle Home/Work/Cell

Address \_\_\_\_\_ Zip Code \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Relationship \_\_\_\_\_

Unless you object, we may use or disclose information to a family member or other persons identified by you who are involved in your care or the payment of your health care.

*(This authorization is valid until notification by patient to cancel authorization is received in writing or verbally, whichever comes first).*

**INSURANCE INFORMATION: IT IS YOUR RESPONSIBILITY TO TELL US IN ADVANCE IF THERE ARE ANY SPECIAL REQUIREMENTS FOR YOUR INSURANCE COMPANY, e.g., PRE-AUTHORIZATION OF PROCEDURES OR HOSPITAL ADMISSIONS.**

All accounts are due and payable at the time of visit unless other arrangements are made at the time of appointment. I understand that I am responsible for any and all balances owing. I hereby authorize the Physician(s) of Digestive Health Clinic, LLC & Idaho Endoscopy Center to release any information acquired in the course of my treatment to my insurance company. Additionally, I authorize any insurance payments to be made directly to the Physician(s) of the Digestive Health clinic, LLC & Idaho Endoscopy Center for any and all medical or surgical services rendered.

Signature \_\_\_\_\_

I hereby acknowledge that I have received a copy of the Digestive Health Clinic, LLC Notice of Privacy Practices on this date or on a previous date. Initial _____
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**MEDICARE  
PATIENT'S ASSIGNMENT AUTHORIZATION  
(For Medicare covered patients only)**

I request that payment of authorized Medicare benefits be made on my behalf to Digestive Health Clinic, LLC for any services furnished to me by their physicians. I authorize any holder of medical information about me to be released to the Centers for Medicare and Medicaid Services and its agents to determine these benefits or the benefits payable for related services.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

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**MEDIGAP SIGNATURE ON FILE**

\_\_\_\_\_  
Name of Patient

\_\_\_\_\_  
Medicare Claim Number

\_\_\_\_\_  
Medigap Policy

I request that payment of authorized Medigap benefits be made on my behalf to Digestive Health Clinic, LLC for any services furnished to me by their physicians. I authorize any holder of medical information about me to be released to \_\_\_\_\_  
(Name of Medigap insurer/  
to determine these benefits. secondary insurance carrier)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature