ASSOCIATES IN GASTROENTEROLOGY, PC

E. Anthony Ugheoke, M.D., F.A.C.G. Board Certified in Gastroenterology

Patient Information Form - Please print all information in the space provided.

Last Name _____ First Name _____ Initial _____

Male ____ Femal ____ Social Security ____/_____/_____ DOB ____/____/____ Marital Status _____

Home Address: _____ City _____ ST _____ Zip _____

Mailing Address if different _____

Home# _____ Work # _____ Cell# _____

OK to leave message at: Home ____ Work ____ Cell ____ Email: _____

Disabled _____ Retired _____ Not Employed _____ Student FT _____ PT _____

Employer: _____ Address: _____ FT _____ PT _____

Emergency Contact _____ Phone _____ Relation _____

Pharmacy _____ Location _____

Referring Physician _____ Primary Care Physician _____

Primary Insurance Carrier _____ ID# _____

Group # _____ Insured Date of Birth _____/_____/_____

Name of the Insured _____ Relation to Patient _____

Second Insurance Carrier _____ ID# _____

Group # _____ Insured Date of Birth _____/_____/_____

Name of the Insured _____ Relation to Patient _____

Third Insurance Carrier _____ ID# _____

Group # _____ Insured Date of Birth _____/_____/_____

Name of the Insured _____ Relation to Patient _____

I hereby authorize payment of medical benefits billed to my insurance. I hereby accept full responsibility for payment for any service(s) provided to me but not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance, if the Practice does not participate with my insurance. I agree to pay all copayments, coinsurance and deductibles at the time service is rendered.

I will pay by (check all that apply) Cash _____ Check _____ Credit Card _____

_____ _____

Signature of Patient or Guardian/Responsible Party Date

809 Shoney Drive * Suite 202 * Huntsville, AL 35801-5306 * Phone: (256) 883-0098 * Fax: (256) 883-0733