Milford Gastroenterology Associates
Phone (508) 478-6363 Fax (508) 473-2636

Patient Information

Date: _____

Patient name: _____ Home phone: _____

Address: _____ Work/cell phone: _____

Town: _____ State: _____ Zip code: _____

Date of birth: _____ Primary care physician: _____

Patient's employer: _____

Emergency contact: _____ Relationship to you: _____ Phone: _____

Treatment of minors: Patients under the age of 18 may not be seen unless accompanied by a legal guardian or unless we receive a signed authorization from the legal guardian allowing the physician to provide medical treatment. The person accompanying the patient is responsible for all copayments or other money due at the time of service.

Pharmacy Information

Pharmacy name: _____ Pharmacy address/phone: _____

Insurance Information ** Please provide us with a copy of your card(s)

Subscriber (if other than self) - Relation to patient (circle one): Self Spouse Child Other

Subscriber Social security #:_____ Date of birth: _____

Do you have a Secondary insurance: YES NO

Do you require a referral for a specialist: YES NO

I authorize Milford Gastroenterology Associates, Inc., to release any and all medical information to the above-named insurance carrier for purpose of claims administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of signing until revoked in writing. I understand that I may request a copy of this authorization. I have read this authorization and understand it. I hereby authorize Milford Gastroenterology Associates, Inc., all money to which I am entitled for medical and/or surgical expenses related to the services rendered, but not to exceed my indebtedness to said physicians and/or surgeons. It is understood that any money received from the above-named insurance company, over and above my indebtedness, will be refunded to me when my bill is paid in full. I understand that I am financially responsible for charges not covered by this assignment. I further agree that in the event of non-payment, to bear cost of collection, and/or court costs and reasonable legal fees should this be required.

Release for services provided without a referral:
As an HMO member, I understand that I have an obligation to obtain the necessary insurance referral from my primary care physician prior to arriving at my appointment. I acknowledge that if I do not have a referral and the claim is denied, I will be responsible for payment in full.

_____ _____

Insured or Guardian Signature Patient Signature

Revised June 2011