PATIENT INFORMATION

Thank you for choosing our office. In order to serve you properly we will need the following information. All information will be strictly confidential. Please **print** in the blanks provided below.

Name: Last:_____________________ First:__________________ Middle:______________________ Maiden__________________

Mailing Address_____________________________________ City_____________________ State________ Zip Code____________

Home Phone # ______________________ Cell Phone #________________________ Work Phone # _____________________

Family/Primary Care Physician __________________________ Referring Physician _______________________

Date of Birth_____/____/_______ Gender: Male/Female Marital Status______________ Social Security #: ________-_____-_________

Would you like to receive text messages regarding your scheduled appointment? Yes/No

Email address________________________________ This will provide you access to our patient portal for appointment reminders, office visit summaries, prescription refill requests, and health reminders.

Race _________ Circle Ethnicity: Hispanic/Latino Non-Hispanic Pharmacy Name & City________________________________

**Name and telephone number of nearest relative/friend not living with you:* ___________________________________

**Please list any person(s) that you give permission to IGA to discuss your medical and/or billing information:

____ ____

INSURANCE INFORMATION:

***Primary Insurance**: ____

If covered under spouse or other person:
Name of Policy Holder: ____________________________________Policy Holder's Date of Birth (ie: spouse) ______/______/_________

Social security number of policy holder (ie: spouse) __________-______-______________

If your insurance is provided by your employer, please provide the name of the company: ________________ ______________________
Employer Phone #: _____________________

***Secondary Insurance:** ____

If covered under spouse or other:
Name of policy holder ____ Date of Birth ______/______/_________

Social security number of policy holder (ie: spouse) __________-______-____________

If your insurance is provided by your employer, please provide the name of the company: ________________ ______________________
Employer Phone #: _____________________

PATIENT'S OR AUTHORIZED SIGNATURE:
I hereby irrevocably assign and transfer to Iberia Gastroenterology Associates, Inc. any and all benefits to which I am entitled or which are available to me under any medical, health and accident, or workers' compensation policy, plan, or program. I hereby authorize and direct that any such payments be paid directly to Iberia Gastroenterology Associates, Inc. I hereby further assign and transfer to Iberia Gastroenterology Associates, Inc. any and all rights under La. R.S. 22:657(A), La. R.S. 23:1201.2,29 USCA 1132, or any similar statutes for penalties, attorneys fees and costs for failure of any insurance company, or medical, health and accident, or workers' compensation policy, plan, or program to timely pay a claim for services rendered to me. I further authorize and agree that a carbon or photostatic reproduction of this assignment shall be effective as an original. I also authorize any overpayment due to me on this account, first be credited to any outstanding patient share balances that I have incurred. Should my account be referred to a collection agency for collection, I will assume responsibility for all collection and/or attorney fees incurred.

Signature____ Date______________________________

********* ALL SERVICES ARE PAYABLE AT THE TIME OF THE VISIT *********