Bruce A. Salzberg M.D., F.A.C.G
Gastroenterology Consultants P.C.

Patient Number _____

Patient Registration

Date: _____

Patient Information

Social Security # _____

First Name _____ Middle Initial ___

Last Name _____

Date of Birth ___/___/___ Gender ☐Male ☐Female

Driver's License #_____ State ____

Primary Address:

_____

City_____ State_____ Zip _____

Email Address:

_____

☐ Employed FT ☐ Employed PT ☐ Student FT
☐ Other _____

Employer _____

Employer Address _____

Suite_____ City_____

State_____ Zip_____

Employer Phone _____

Referring Physician _____

Phone Numbers – Important – Please fill out.

Home Phone _____

Work Phone _____

Cell Phone _____

How did you hear of us?

Insurance Information -- Please provide your insurance cared to the receptionist

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Worker's Compensation ☐ Other _____

Insurance Company: _____ Policy #_____ Group #_____

Insured / Card Holder's Name_____ Relationship to Patient _____

Insured D.O.B. ___/___/___ SSN#_____ Phone_____

Employer _____ City / State _____ Phone_____

Secondary Insurance Information -- Please provide your insurance cared to the receptionist

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Worker's Compensation ☐ Other _____

Insurance Company: _____ Policy # _____ Group # _____

Insured / Card Holder's Name_____ Relationship to Patient _____

Insured D.O.B. ___/___/___ SSN#_____ Phone _____

Employer _____ City / State _____ Phone _____

Pharmacy Information

Pharmacy Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Emergency Contact

Full Name (First, Middle Initial, Last) _____

Relationship to Patient _____ Gender ☐ Male ☐ Female

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

_____
Signature (Patient or Parent, if minor) Date

_____
Signature (Patient or Parent, if minor) Date