Gastroenterologists of Ocean County
Endoscopy Center of Ocean County Endoscopy Center of Toms River

Patient Demographics Sheet

Please PRINT Clearly

Today's Date: _____ Date of Birth:_____ Age:_____ Social Security #:_____

Patient Name: _____ Gender: M F
(First) (M) (Last)

Marital Status: S M W D Sep Spouse Name: _____ Spouse Date of Birth: _____

Home Address: _____
(Street) (Apt.) (City) (State) (Zip Code)

Home Phone: _____ Cell: _____ Alt Phone:_____

Email Address: _____ Language Spoken: _____

Emergency Contact: _____ Phone: _____ Relationship:_____

Allergies: (Patient, please list) _____

_____

Responsible Party: _____ Relationship: _____

Patient Employer: _____ Occupation: _____ Retired? Y N

Employer Address: _____Phone: _____

Spouse's Employer: _____ Address: ___ _____

Referring Physician: _____Address: _____

Phone: _____ Fax: _____

Pharmacy Name/Location: _____ Pharmacy Phone: _____

Primary Insurance Company:_____ Subscriber Name: _____

Date of Birth: _____ Relationship: _____

Secondary Insurance Company: _____ Subscriber Name: _____

Date of Birth: _____ Relationship: _____

Do you have a Living Will? Yes ☐ No ☐

Any Special Needs: (Please Circle) Hearing Vision Language Religion or Cultural

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Please check the applicable authorizations and sign below:

_____ AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:

I hereby authorize Gastroenterologists of Ocean County, P.A. and/or present associates, singly, jointly, or severally, to release my medical records to my referring physician, my family physician, and/or any other physicians that I may request.

_____ AUTHORIZATION FOR ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize Gastroenterologists of Ocean County, P.A. and or present associates, singly, jointly, or severally, to release such information as required by my attorney and/or insurance company concerning my illness and treatment and I hereby assign to the physician all payments for medical services rendered. I also hereby understand that I am financially responsible for services charged regarding treatment.

_____ AUTHORIZATION FOR MEDICARE BENEFITS:

I hereby request that payment of authorized Medicare benefits be made either to me or on my behalf to Gastroenterologists of Ocean County, P.A. and/or present associates, singly, jointly, or severally, for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to the Healthcare Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in line 9 of the HCFA-1500 Form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based on the charge determination of the Medicare carrier.

_____ AUTHORIZATION FOR MEDIGAP BENEFITS:

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Gastroenterologists of Ocean County, P.A. and/or present associates, singly, jointly, or severally, for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to Medigap Insurer any information needed to determine these benefits payable for related services.

_____ _____
Signature of Patient/ Insured Date

"A photocopy of this form shall be deemed as valid and effective as the original."

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Authorization To Disclose Personal Health Information

Patient Name: _____

I hereby authorize the staff of GOC to have communications regarding my personal health information with:

Name	**Relationship**
_____	_____
_____	_____
_____	_____
_____	_____

I hereby authorize the staff of GOC to disclose copies of my personal health information to:

Name	**Relationship**
_____	_____
_____	_____
_____	_____
_____	_____

Patient Signature: _____ Date: _____

If legal representative, sign below and state relationship.

Legal Representative: _____ Relationship: _____

Witness: _____ Date: _____

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Consent For Release of Information for Treatment, Payment and Health Care Operations

I, _____, hereby authorize GOC to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, GOC can refuse to treat me.

I have been informed that GOC has prepared a notice ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying GOC, in writing, but if I revoke this consent, such revocation will not affect any actions that GOC took before receiving my revocation.

I understand that GOC has reserved the right to change his/her privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that GOC restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment, or health operations. I understand that GOC does not have to agree to such restrictions, but that once such restrictions are agreed to, GOC must adhere to such restrictions.

_____ _____

Signature of Patient or Patient's Representative
(Form **MUST** be completed before signing)

Date

_____

Printed Name of Patient or Patient's Representative

_____

Relationship to Patient