

# La Jolla Endoscopy Center

My appointment today is with Dr. \_\_\_\_\_

Patient \_\_\_\_\_  
(Last Name, First Name, MI)

Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_  
(Street Number)

Gender \_\_\_\_M \_\_\_\_F Marital Status \_\_\_\_\_

City \_\_\_\_\_

Social Security Number \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_

E-Mail address \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_

Employer \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_  
Phone Number \_\_\_\_\_

Insurance Carrier Primary \_\_\_\_\_  
Secondary \_\_\_\_\_

Referred By \_\_\_\_\_ Primary Physician \_\_\_\_\_

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**Authorization to pay benefits to physician:** I hereby authorize payment of medical and/or surgical benefits directly to La Jolla Gastroenterology Medical Group, Inc. for services described on the insurance claim forms. I realize that the insurance payment may not represent full payment for services rendered and I will be responsible for the balance due including, but not limited to, deductibles, co-pays, co-insurances, and services not covered under my plan. It is my responsibility to know the coverage of benefits for my insurance policy. I agree to remit payment within 30 days of receipt of a statement and understand that La Jolla Gastroenterology Medical Group charges \$5.00 for each past due statement generated for any unpaid balances.

**Authorization to release information:** I hereby authorize the release of any medical or other information necessary to my insurance company to process claims for services rendered.

**HIPAA Policy:** I hereby acknowledge receipt of the Notice of Privacy Practices of La Jolla Gastroenterology.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date