REGISTRATION FORM

NORTHWEST GASTROENTEROLOGY ASSOCIATES

NWGA Only:
Account # ____________
Initials: ____________

Today's Date _____ /_____ /_____

PATIENT INFORMATION *(Please Print)*

Full Name ______________________ (LAST) ______________________ (FIRST) ____ (MI) Sex ❑ Male ❑ Female

Social Security # ______________________ Birthdate ______________ Age ________

Mailing Address ______________________ City ____________ State ______ Zip ________

Street Address ______________________ City ____________ State ______ Zip ________

Home Phone ______________ Work Phone ______________ Cell Phone ______________

Messages can be left on: ❑ Home Answering Machine ❑ Work Voicemail ❑ Cell Voicemail

Employer ______________________ Occupation ______________

Marital Status ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Legally Separated ❑ Other ________

Referred to NWGA by: ______________________ Primary Care Physician: ______________

INSURANCE INFORMATION

Primary Insurance Company

Insurance Name ______________________ Subscriber's Relationship to Patient: (check one) ❑ self ❑ spouse ❑ parent ❑ other

Subscriber Name ______________________ Date of Birth ______________ SSN ______________

Policy ID # ______________________ Group # ______________ Copay $ ________

Secondary Insurance Company

Insurance Name ______________________ Subscriber's Relationship to Patient: (check one) ❑ self ❑ spouse ❑ parent ❑ other

Subscriber Name ______________________ Date of Birth ______________ SSN ______________

Policy ID # ______________________ Group # ______________ Copay $ ________

RESPONSIBLE PARTY INFORMATION *Complete — if child is a minor*

Full Name ______________________ Relationship to Patient: (check one) ❑ parent, ❑ other

Mailing Address ______________________ City, State, Zip ______________________

EMERGENCY CONTACT

Name ______________________ Day/Work Phone (________) ______________

Relationship to Patient ______________________ Home/Eve Phone (________) ______________

RELEASE OF INFORMATION — *Read Carefully*

As a patient you have certain responsibilities for your care. Those responsibilities include:

- Providing current, accurate billing information at all visits.
- Provide physician with complete medical history.
- Being aware of which benefits your insurance does and does not cover.
- Failure to cancel appointments 24 hrs. in advance may result in a fee.

I authorize the physicians and staff of Northwest Gastroenterology Associates to release information regarding my condition and/or treatment to:

______________________ NAME ______________________ RELATIONSHIP

Northwest Gastroenterology Associates is actively involved in research. You may be identified as a possible study candidate. If so, your physician would like to share your medical record with individuals involved in this research and you will be notified if you meet the criteria. At that time you may elect to participate in the study or decline.

Please indicate if you consent to the sharing of your medical records for purposes of drug research. Checking "I do" does not place you under obligation to participate in a study.

Please initial: { ________ } I do { ________ } I do not

I hereby authorize my insurance benefits to be paid directly to Northwest Gastroenterology Associates and I am financially responsible for any balance due. I authorize Northwest Gastroenterology Associates to release any information necessary to process an insurance claim, including industrial injury.

My Signature acknowledges understanding and consent to all of the above information.

Signature ______________________ (PATIENT OR PARENT/GUARDIAN IF SIGNING FOR MINOR) Date ______________

How did you find out about our office? (check one) ❑ Existing ❑ Patient ❑ Family ❑ Friend ❑ Insurance ❑ Another MD ❑ ER ❑ Yellow Pages ❑ Overlake Referral Line ❑ Other