



**THE
GASTROENTEROLOGY
GROUP**
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**PATIENT INFORMATION
FOR MEDICAL RECORDS**

(Please Print)

Patients Full Legal Name _____ SS # _____

Address _____ City/State _____ Zip _____

Home Phone () _____ Date of Birth _____ Sex Male Female

Employed by _____ Work # () _____

Work Address _____ Occupation _____

Marital Status: Married Single Divorced Widow

Spouse's Full Legal Name _____ Spouse's SS # _____

Spouse's Date of Birth _____ Spouse Employed By _____

Spouse's Work # () _____ Spouse's Occupation _____

Spouse's Work Address _____

If patient is a minor who is responsible for bill? _____ Relationship _____

Address of responsible party _____ City/State _____ Zip _____

Home Phone () _____ Work # () _____

NAME OF PARENT, NEAREST RELATIVE, OR FRIEND TO CONTACT IN EMERGENCY.

Name: _____ Relationship: _____ Phone # () _____

HOW DO YOU INTEND TO PAY? CASH CHECK VISA/MC

INSURANCE INFORMATION

DO YOU HAVE MEDICARE? YES NO Medicare # _____

First Insurance Company: _____

Address _____ City, State, Zip _____

Policy # _____ Group # _____

Insured's Name _____ Insured's Relationship to Patient _____

Insured's Date of Birth _____ Insured's SS # _____

Secondary Insurance Company: _____

Address _____ City, State, Zip _____

Policy # _____ Group # _____

Insured's Name _____ Insured's Relationship to Patient _____

Insured's Date of Birth _____ Insured's SS # _____

REFERRED BY _____

REASON FOR TODAY'S VISIT _____

HOW LONG HAVE YOU BEEN HAVING THIS PROBLEM? _____

PLEASE SIGN AND RETURN TO THE RECEPTIONIST. PLEASE HAVE INSURANCE CARDS OUT SO THAT WE MAY COPY THEM.

I, the undersigned, have insurance coverage with _____
and assign directly to the Gastroenterology Group all surgical and/or medical benefits, if any, otherwise payable to me for services rendered.
I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all
information necessary to secure the payments of benefits.

Date _____ Signature _____