PRINT

SOUTHWEST GASTROENTEROLOGY / OAK LAWN ENDOSCOPY
REGISTRATION – Page 1 of 2

PATIENT INFORMATION	IMPORTANT: SPECIFY OFFICE LOCATION: Select Location	
Last Name:	County:	Home#:
First Name:	Country: USA	Cell#:
Address:	Sex: F	Work#:
City:	DOB:	Email:
State: IL	Marital Status: Married	(email for healthcare purposes only)
Zip Code:	Language:	SS#:

STATE REPORT PURPOSES ONLY	
Race: Select Race	Ethnicity: Select Ethnicity

PHYSICIAN INFORMATION		
Southwest Gastro Physician: Select SG Physician		
PCP:	Telephone:	Address:
Referring Physician:	Telephone:	Address:

HOW WERE YOU REFERRED TO US?: How were you referred to us?

EMPLOYER INFORMATION	
Employer:	Status: Employed Full Time
Address:	
City, St, Zip:	Employer Telephone:

EMERGENCY CONTACT (outside of home)		
Name:	Telephone#:	Relationship:

INSURANCE INFORMATION	
PRIMARY:	SECONDARY:
Ins Name:	Ins Name:
Claim Address:	Claim Address:
City, St:	City, St:
Zip Code:	Zip Code:
Policy Holder:	Policy Holder:
Pol Holder Employer:	Pol Holder Employer:
Group#:	Group#:
Policy/ID#:	Policy/ID#
Pt Rel to Holder:	Pt Rel to Holder:
Holder's Sex:	Holder's Sex:
Holder's DOB:	Holder's DOB:
Annual Deductible:	Annual Deductible:
Spec Copay:	Spec Copay:
Claim Telephone#:	Claim Telephone#:
Eligibility Telephone#:	Eligibility Telephone#:

IF YOUR INSURANCE REQUIRES REFERRALS, CHECK HERE ☐

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AUTHORIZATION, ASSIGNMENT OF BENEFITS, AND RELEASE OF INFORMATION

I hereby authorize Southwest Gastroenterology and Oak Lawn Endoscopy to give me reasonable and proper medical care by today's standards. I also authorize you or your designee to release all medical information to any third party payor, employer, peer review organization, pre-certification organization, managed care plan, health facility, or physician for the purpose of payment of charges or for further medical treatment. In consideration of medical services provided, I hereby authorize assignment of insurance benefits. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

Excluding Medicare patients, I understand that I am responsible for any and all charges not paid by my medical insurance. I understand that I am responsible for all fees regardless of insurance coverage. (FORMS WILL BE SIGNED AT OFFICE VISIT)

Patient Date

Parent or Guardian (if patient is a minor) Date

Medicare Patients (only):

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Southwest Center for Gastroenterology for any services furnished to me by Southwest Center for Gastroenterology. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or any benefits for related services.

Patient Date