



ELGIN GASTROENTEROLOGY

Welcome to Elgin Gastroenterology, S.C.. Thank you for completing both sides of this Patient Registration Form. If you would like to take home copies of any forms completed today, please just ask your Registrar.

Date of Birth	____/____/____	Gender	<input type="checkbox"/> M	<input type="checkbox"/> F	
Last Name	_____	First Name	_____	MI	_____
Address _____					
Home Phone	_____	Other Phone	(<i>cell/work</i>) _____		
SSN	_____	Employer	_____		
Who is policy holder on your primary insurance? <input type="checkbox"/> me <input type="checkbox"/> spouse <input type="checkbox"/> parent					
If primary policy holder is a spouse or parent, then please provide the following:					
Last Name	_____	First Name	_____	MI	_____
Address (if other than yours) _____					
Date of Birth	_____	Employer	_____	SSN	_____
Who is the physician who referred you to our practice? _____					
Emergency contact person name: _____ Phone: _____					
I am interested in receiving email information regarding Elgin Gastroenterology, S.C., or any series, seminars, or publications they may offer on digestive health or digestive disease management. I understand that my email address will not be provided to any party outside of the practice. <input type="checkbox"/> Yes <input type="checkbox"/> No Email address _____					

<p>In accordance with Illinois law, I understand that if any person employed by Elgin Gastroenterology, S.C., is directly exposed to my body fluids in any manner which may transmit the human immunodeficiency virus (HIV), that I may be tested for infection with HIV. I further understand that Illinois law allows for the release of these test results to the person who is exposed to my body fluids. (Public Health (410 ILCS 305/7))</p> <p>I also agree that if any person employed by Elgin Gastroenterology, S.C., is directly exposed to my body fluids in any manner which may transmit viral hepatitis, that I may be tested for infection with viral hepatitis. I further agree to the release of these test results to the person who is exposed to my body fluids.</p> <p style="text-align: right;">_____ Initial</p>

Assignment of Insurance Benefits

I hereby authorize payment to Elgin Gastroenterology, Provena St. Joseph Hospital, Sherman Hospital, and/or any reference laboratory, for benefits herein specified and otherwise payable to me for any services rendered subsequent to this date, and for such other charges as may be made by previously mentioned providers of medical care. This assignment will remain in effect until revoked by me in writing. A copy of this assignment is to be considered as valid as the original.

Initial

Authorization to Leave Messages

I hereby authorize Elgin Gastroenterology, S.C. to leave a message on my home voice mail, answering machine, or other electronic device, or with a person who answers my home phone, in regards to my health, my appointment, or my financial obligations to Elgin Gastroenterology, S.C..

Initial

Authorization to Release Information

I hereby authorize Elgin Gastroenterology, S.C., Provena St. Joseph Hospital, Sherman Hospital, and/or any reference laboratory to release any and all information to insurance companies or associations, employee groups, government agencies, or their third party payors and their agent or employees, either by mail or electronically as may be necessary for the completion of my claims. If said records should be received by another party in error, I absolve the practice of any liability related to such submission of said records.

Initial

I certify that the information provided *on both sides* of this form is correct to the best of my knowledge. I have read and understand the above and duly authorize Elgin Gastroenterology, S.C., and/or its appointees to execute the above and its terms.

Patient Signature:	Date:
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If above patient is a minor (<18 years of age on date of service), signature by parent or guardian is required:

Parent/Guardian (if applicable):	Date:
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If above patient has granted power of attorney, then agent must sign below:

Designated Agent for Above Patient:	Date:
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