ALISTER A. GEORGE, M.D.
GASTROENTEROLOGY & HEPATOLOGY
Board Certified in Gastroenterology

PATIENT INFORMATION FORM

Please Print and Complete All Entries

PATIENT NAME (Last – First – Middle Initial) ☐ ☐ ☐ Mr. Ms. Mrs.			DATE OF BIRTH	AGE / MARITAL STATUS S( ) M( ) D( ) W( )
STREET ADDRESS				HOME PHONE ( )
CITY – STATE – ZIP				CELL PHONE ( )
E-MAIL ADDRESS				WORK PHONE ( )
PATIENT'S EMPLOYER		EMPLOYER ADDRESS		
SOCIAL SECURITY NO. (SSN)	OCCUPATION	[ ] FULL-TIME [ ] PART-TIME [ ] STUDENT		DRIVERS LICENSE NO.
NAME OF SPOUSE	SPOUSE DATE OF BIRTH	AGE		SPOUSE SSN
SPOUSE EMPLOYER	SPOUSE EMPLOYER ADDRESS			SPOUSE WORK PHONE NO.
NEAREST RELATIVE NOT LIVING WITH YOU	Address	RELATIONSHIP		RELATIVE'S PHONE NO. ( )
IN CASE OF EMERGENCY, NOTIFY:				EMERGENCY CONTACT PHONE NO. ( )
REFERRED TO THIS OFFICE BY:	Address			PHONE NO.
WHO IS FINANCIALLY RESPONSIBLE FOR PAYMENT?				**I WILL BE PAYING TODAY BY:** **[ ] Check [ ] Cash** **[ ] Credit Card [ ] Payment Plan**

INSURANCE INFORMATION

PRIMARY INSURANCE NAME **Address**			PHONE NUMBER ( )
NAME OF INSURED	RELATIONSHIP TO INSURED	I.D. No.	GROUP OR POLICY NO.
SECONDARY INSURANCE NAME **Address**			PHONE NUMBER ( )
NAME OF INSURED	RELATIONSHIP TO INSURED	I.D. No.	GROUP OR POLICY NO.

I certify by my signature below that I understand and agree that I am ultimately responsible for payment. I further certify that this information is true and correct to the best of my knowledge.

Patient Signature_____ Date _____

I hereby authorize ALISTER A. GEORGE, MD to release any medical information needed by my insurance company. I furthermore authorize payment directly to ALISTER A. GEORGE, MD for any insurance payments or benefits otherwise payable to me. THIS IS TO INCLUDE ANY MAJOR MEDICAL BENEFITS IN ADDITION TO BASIC BENEFITS PAYABLE. A copy of this authorization shall be as valid as the original. I understand that I am liable for any fee not paid by insurance benefits.

Patient Signature _____ Date _____