Gastro Consultants of Atlanta, P.C.

Specialists in Digestive and Liver Diseases
Alan M. Fixelle, M.D., F.A.C.G.

www.gastroconsultantsatlanta.com

PATIENT NAME:_____
LAST **FIRST** **MI**

_____
ADDRESS **CITY** **STATE** **ZIP**

Date of Birth:_____ Telephone #: _____ Cell phone: _____

Circle one: MALE / FEMALE Email address:_____

Marital Status: ___Married ___Single ___Widowed ___Divorced ___Partnered

Optional: _____ White _____African American _____Asian _____Hispanic _____ Other_____

Language: _____English _____Spanish _____French _____Other _____ _____Refuse to report

Emergency Contact:_____Telephone:_____

Primary Insurance Co. (*Please list both name and address*):_____

_____

Policy Holder Name:_____ ID#:_____ Grp#:_____

Secondary Insurance Co. *(Please list both name and address)*:_____

_____

Policy Holder Name:_____ ID#:_____ Grp#:_____

Referring Physician:_____Telephone _____

Primary Care Physician:_____Telephone _____

INSURANCE AUTHORIZATION/ASSIGNMENT:

I hereby authorize **Gastro Consultants of Atlanta, P.C.** to release necessary information to insurance carriers acquired in the course of my treatment, and assign payment for services rendered.

Signature:_____ Date:_____

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