San Diego Gastroenterology Medical Associates

PATIENT INFORMATION FORM

Today's Date (Fecha):	Primary Care Physician (Nombre de Su Medico General):

PATIENT INFORMATION

First Name (Primer Nombre):	Middle:	Last Name (Apellido):

Date of Birth (Fecha de Nacimiento):	Age (Edad):	Sex (Sexo):	Marital Status (Estado Civil):

Address (Direccion):	City (Ciudad):	Zip Code:

S.S.# (Tricare or Medicare Only)	Home Phone # (# de Telefono):	Cell Phone # (# de Celular):
Occupation (Ocupacion):	Employer (Empleado):	Work Phone # (# de Empleo):

Email Address (Correo Electronico) Required for access to the patient portal.

INSURANCE INFORMATION

PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST

(Por favor dar su tarjeta de seguro a la recepcionista)

IN CASE OF AN EMERGENCY

WHO ARE WE AUTHORIZED TO CONTACT? PLEASE LIST NAME HERE,
BY SIGNING THIS FORM YOU ARE ALLOWING US TO DISCUSS YOUR MEDICAL/HEALTH ISSUES WITH THIS DESIGNATED PERSON.
(PONGA EL NOMBRE DE ALGUIEN QUIEN PODAMOS CONTACTAR EN CASO DE EMERGENCIA)

Name of local friend or relative: (Nombre de Familiar o Amigo)	Relationship to patient: (Relacion del Paciente)	Home Phone # : (# de Telefono)	Cell Phone # : (# de Celular)

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I have read and understand the company's Financial Policy and understand that I am financially responsible for any balance. I also authorize San Diego Gastroenterology Medical Associates or insurance company to release any information required to process my claims.

(La informacion anterior es verdadera para el mejor de mi conocimiento. Autorizo mis beneficios de seguro a pagar directamente al medico y la liberacion de mi informacion para procesar mis reclamos. He leido y entiendo la politica financiera de la empresa y entiendo que soy responsable por cualquier balanza.)

SIGNATURE (Firma): ______________________________ **DATE (Fecha) :** ______________________________