GAMIT

GASTROENTEROLOGY & ADVANCED METABOLIC INSTITUTE OF TEXAS

Patient Registration Form

Patient Information

Full Name: _____

Date of Birth: _____

Gender: □ Male □ Female □ Other

Social Security Number: _____

Marital Status: □ Single □ Married □ Divorced □Widowed

Phone (Primary): _____

Phone (Secondary): _____

Email Address: _____

Address: _____

City: _____

State: _____

Zip Code: _____

Employment Information

Employer: _____

Occupation: _____

Work Phone: _____

Preferred Language: _____

Emergency Contact

Name: _____

Relationship: _____

Phone: _____

GAMIT

GASTROENTEROLOGY & ADVANCED METABOLIC INSTITUTE OF TEXAS

Insurance Information

- Primary Insurance

Company: _____

Policy Holder Name: _____

Policy #: _____Group#:_____

Relationship to Patient: □ Self □ Spouse □ Child □Other

- Secondary Insurance (if applicable)

Company: _____

Policy #: _____

Group #: _____

Primary Care Physician (PCP)

Name: _____

Phone: _____

Referring Physician

Name: _____

Phone: _____

GAMIT Authorization & Consent

I authorize Gastroenterology & Advanced Metabolic Institute of Texas to release medical information to my insurance company and to process claims for services rendered. I consent to treatment as deemed necessary by the healthcare providers of the clinic.

Patient/Guardian Signature: _____

Date: ____ / ____ / _____

4441 Long Prairie Rd, Suite 100, Flower Mound, TX 75028 Phone: (469) 933-2253 Fax: (469) 933-2254