Center for Gastrointestinal Medicine Patient Registration Form
500 West Putnam Avenue – Suite 100
Greenwich, Connecticut 06830

For Office Use: Act # ______________________ Date form completed:____________

First Name_________________________ Init: ________ Last Name:_____________________________

Address_______________________________________ City______________ St______ Zip___________

Telephone: Home______________ Work ___________________ Cell________________ Sex: M – F

Marital Status: M – S – D Date of Birth _____________ Age ________ SS#_______-______-_______

Employer____

Address____

City____________________________ State____________________ Zip________ Tele: _____________

How did you hear about our practice? ____

Primary Care Physician: ____

Primary Care Address: ____

City_________________________ State________________ Zip_________ Tele: ___________________

Primary Insurance Carrier________________________________ Policy Owner _____________________

Patient Insurance ID# _________________________Relationship (circle) Self - Spouse - Depend

Group# __________________________ Contract #____ ____________ Co-pay Y – N Amount________

Do you have any medication allergies? If yes, name drug____

May we call your cell phone if we need to reach you? Y - N
May we leave messages on your home message machine as they pertain to lab results, appointments and benign pathology if we are unable to reach you in person? Y – N

It is required that the Center for Gastrointestinal Medicine of Fairfield and Westchester, PC keep a copy of your signature on file for billing purposes. This enables us to bill your insurance company for services rendered at the time of each visit electronically. Please sign below that you authorize the use of your signature for billing purposes.

- You will be provided with a copy of our office privacy policy at the time of your visit.

Signature________________________________ Print Name_______________ Date _________________