HACKENSACK GASTROENTEROLOGY ASSOCIATES, P.A.

NAME_____ SS#_____

ADDRESS_____

CITY_____STATE_____ ZIP CODE_____

D.O.B._____ AGE____ EMAIL ADDRESS:_____

HOME PHONE:_____CELL:_____

EMERGENCY CONTACT:_____PHONE:_____

PRIMARY CARE PHYSICIAN_____

EMPLOYED BY_____PHONE:_____

ADDRESS_____

SPOUSE OR PRIMARY INSURANCE SUBSCRIBER'S INFORMATION:

NAME_____D.O.B._____

EMPLOYED BY_____

ADDRESS_____

I hereby authorize Hackensack Gastroenterology Associates to furnish information to insurance carriers concerning my illness and treatment. I hereby assign to the physicians all payments for medical services rendered to my dependents or myself. I understand that I am responsible for anything not covered by my insurance.

I hereby authorize Hackensack Gastroenterology Associates to import my medication history from participating pharmacies in the interest of safe prescribing practices.

I have been informed of Hackensack Gastroenterology Associates' Notice of Privacy Practices in accordance with HIPAA compliance, effective date of 4/14/03. I understand that I may request a copy of this information at any time.

SIGNATURE:_____DATE:_____