SAN FRANCISCO GASTROENTEROLOGY
WWW.SFGIMD.COM

REGISTRATION FORM

NAME:_____
First Middle Last

Do you have a preferred first name (e.g. Bob instead of Robert):_____

Home Address:_____APT#____ _____
Street City State/ZIP

Gender : □ F □ M **Birth Date**:_____ **Social Security#** _____

Contact: (_____)_____ (_____) _____ (_____) _____
(Home Number) **(Work Number)** **(Cell Number)**

Employed By_____**Occupation**_____

Person to contact in case of emergency_____
Name Relationship Phone Number

Pharmacy: _____ Phone (_____)_____

Primary Care Physician's Name:_____

Address:_____City_____State_____Zip_____

Phone Number:_____Fax Number:_____
(Please use back of form to add additional physcians who you would like copies of your procedure/medical reports mailed to)

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

By signing below I certify that I have disclosed all of my insurance coverage at the time of my appointment. If there are any changes or additions in my benefits or coverage, I will contact the physician's office and notify them of such changes. I understand that my insurance will be billed as a courtesy and any remaining balance including co-payments not rendered at the time of service will be forwarded to me in a timely manner. I hereby authorize payment directly to the physician on my behalf for services provided to me. I understand that I am ultimately responsible for fees for professional services as well as any non-covered services provided. I authorize the physician to release all information necessary to secure the payments of benefits.

There is a 24-hour cancellation policy for office visits. There is a 72- hour (3 business days) cancellation policy for procedures. You will be charged a cancellation fee if you fail to notify our office within the above mentioned guidelines.

X _____ **Date**:_____
(Signature of Patient OR Guardian)

STAFF ONLY: NP/ FP CURRENT DOS:_____ NO CHANGE FROM LAST DOS:_____

PATIENT INITIAL:_____ STAFF INITIAL:_____ MD SIGNATURE:_____