Gastroenterology Consultants of West Houston

*****PATIENT INFORMATION*****

Please review and correct any information that has changed since your last visit to our office. Please return this form to the Check-in window before being called to see the doctor. Thank you for your cooperation.

ACCOUNT#:_____ NAME: _____

Address: _____

HOME PHONE#:_____WORK#: _____CELL #: _____

DATE OF BIRTH:_____ AGE:_____ MARITAL STATUS:_____

SOCIAL SECURITY: _____ GENDER: _____

RACE:_____ ETHNICITY: ❒ HISPANIC ❒ NONHISPANIC ❒ DO NOT DESIRE TO REPORT LANGUAGE: _____

EMAIL ADDRESS: _____

LOCAL PHARMACY: Name _____ Phone number_____

EMERGENCY CONTACT NAME & RELATIONSHIP: _____

EMERGENCY CONTACT PHONE NUMBER: _____

PATIENT EMPLOYER: _____ EMPLOYER PHONE: _____

FIRST AND LAST NAME OF PRIMARY CARE DOCTOR: _____

PROVIDER: Hyon S. Kang. M.D.

WERE YOU REFERRED TO OUR OFFICE? ____YES ____ NO, if yes who _____

INSURANCE CO:_____ SECONDARY INS: _____

INSURED ID#: _____ INSURED ID#:_____

INSURED: _____ EMPLOYER: _____

INSURED DOB: _____ RELATIONSHIP: _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the physician for services rendered I understand that I am responsible for paying any non-covered services.

SIGNATURE OF PATIENT or (Parent if a Minor):_____Date: _____

AUTHORIZATION TO RELEASE OF INFORMATION: I hereby authorize the physician to release information required in the course of my treatment necessary to process insurance.

SIGNATURE: _____DATE: _____