PLEASE FILL OUT AS COMPLETELY AS POSSIBLE

Coastal gastroenterology

Patient's Name: _____ Date of Birth: _____ SSN: _____

Mailing Address: _____ City _____ State ____ Zip _____

Home Phone w/Area Code: _____ Cell/Work Phone w/Area Code: _____

Email Address: _____ Would you like an invitation to our Patient Portal? Y N

Race (Circle one): Declined / American Indian / Asian / Black / Hawaiian / Pacific Islander / White / Other

Ethnicity (Circle one): Declined / Hispanic or Latino / Not Hispanic or Latino

Contact Preference (circle one) Phone: **Home Cell Work / Mail / Fax / Email / Patient Portal**

In Case of Emergency, Contact: _____ Phone #: _____ Relationship _____

Preferred Pharmacy _____

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative

☐ Physician Office, Name of care provider Referring you to our Practice _____

☐ Newspaper ☐ Insurance ☐ Work ☐ Yellow Pages ☐ Internet ☐ Other _____

Are You a Previous Patient of Dr. Bell? ☐ Yes ☐ No

Have You been to a Gastroenterologist before? ☐ No ☐ Yes Name _____

Who is Your Primary Care Physician? _____

Assignment of Benefits and Financial Agreement

I hereby acknowlege that I received or was provided the opportunity to receive a copy of Coastal Gastroenterology, PC Notice of Privacy Practices and Financial Policies. I furthermore authorize this physician to release any information acquired in the course of my examination or treatment and permit payment directly to him at his election, any benefits due me for his service. I recognize and accept my responsibility for any balance or fee not covered by my insurance plan, including any copays. I further agree that a photocopy of this agreement shall be as valid as the original.

Date _____ **Signature** _____

DO YOU HAVE YOUR ADVANCED DIRECTIVE WITH YOU? NO ☐

☐ **YES, PLEASE GIVE IT TO THE FRONT DESK STAFF TO BE SCANNED INTO YOUR CHART**