NORTHEAST GASTROENTEROLOGY ASSOCIATES, P.C.

52 Stiles Road, Suite 110 Salem, NH 03079
Phone (603)898-5082 Fax (603)890-5453

Patient Name _____ M or F DOB ____/____/____

Address _____ City _____ State _____ Zip _____

Social Security Number _____-_____-_____ Marital Status S M W D

Telephone (Home) _____-_____-_____ Work _____-_____-_____ Cell _____-_____-_____

Email Address _____@_____

Patient Employer _____ Address _____

Spouse/Emergency Contact _____ Phone _____-_____-_____

Primary Care Physician _____ Phone _____-_____-_____

Address _____ City _____ State _____

Local Pharmacy _____ Address _____ City _____ State _____

Phone _____-_____-_____ Prescription Insurance ID _____

Insurance Information
Primary Insurance Name _____
Subscriber_____DOB ___/___/___

Primary Insurance ID or Certificate # _____ Group _____

Subscribers' Employer

_____

Secondary Insurance Name _____ Subscriber _____
DOB ___/___/___

Secondary Insurance ID or Certificate # _____ Group
_____

PLEASE READ AND SIGN ALL THREE LINES BELOW

Patient or Authorized Persons Signature.

I authorize the release of medical information top process a claim

SIGNED _____ DATE
_____

I authorize payment of medical benefits to the undersigned physician for services

SIGNED _____ DATE
_____

As an HMO Member, I understand that I have an obligation to obtain a referral for non emergent care from my Primary Care Physician prior to making an appointment. I acknowledge that if I do not have a referral today I will be responsible for payment of services should they be denies by my HMO plan.

SIGNED _____ DATE
_____

All bills must be paid within 30(thirty) days of appointment. All unpaid balances will be assigned to a collection agency and a $ 25.00 collection fee will be added to your bill.