G.A.N.T.
Please complete all blanks: print clearly

Name: ____ Social Security No. ____________________
Last Name *First Name* *M. Initial*

Date of Birth: ____/____/______ Sex: M__ F__ Marital Status: S __ M__ D __ W __ Spouse: ____________________

Street Address: ______________________________ City: ____________ State: ____ Zip: ________

Home phone: ________________ Business phone: ________________ Cell phone: ________________

Employer: ______________________________ Occupation: ______________________________

Address: ______________________________ City: ________________ State: ____ Zip: ________

Emergency Contact: ____________________ Relationship: ______________ Date of Birth: ____/____/______

Address: ____ Phone Number: ________________

Insured's Name: ____ Social Security No. ________________

Date of Birth: ____/____/______ Relationship to patient: ______________________________

Employer: ________________ Occupation: ______________________________ Phone: __________

Address: ______________________________ City: ________________ State: ____ Zip: ________

Primary Insurance Company: ______________________________ HMO: ____ PPO: ____ Other: ________

Address: ______________________________ City: ________________ State: ____ Zip: ________

Group No. ______________________________ Certificate No. ______________________________

Secondary Insurance Company: ______________________________ HMO: ____ PPO: ____ Other: ________

Insured's Name: ______________________________ Relationship to patient: ____________________

Address: ______________________________ City: ________________ State: ____ Zip: ________

Group No. ______________________________ Certificate No. ______________________________

Referred by: ______________________________ Primary Care Physician: ______________________________

Pharmacy Name/Phone/Fax# ____

By completing your name, address, and phone number above, you are hereby giving us permission to mail you documents to your residence in your name that may include patient health information or to call you with patient health information. If you do not wish us to mail you documents regarding your bill, please notify us that you will be åpaying in full at the time of service.

I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.

I understand that insurance does not relieve my financial obligation for this account. I further authorize and request that insurance payments be made directly to Gastroenterology Associates of North Texas, should they elect to receive such payment.

I have read and fully understand my financial responsibility and authorize G.A.N.T. to bill my insurance company.

Signature of responsible party: ____ Date: ____/____/______

Witness: ____ Date: ____/____/______

Please indicate how you wish to pay today's charge: Cash ___ Check ___ MasterCard ___ Visa ___