Inland Empire Gastroenterology Medical Group
Endoscopy Center of Inland Empire
Patient Information

IN ORDER TO BETTER SERVE YOU PLEASE COMPLETE THE INFORMATION TO THE BEST OF YOUR ABILITY. WE ARE REQUESTING EMERGENCY CONTACT INFORMATION IN THE EVENT OF ANY UNFORSEEN SCHEDULE CHANGES OR IN THE EVENT OF AN EMERGENCY DURING YOUR VISIT TO OUR FACILITY.

LAST NAME	FIRST NAME MIDDLE INIT.	Social Security #	
DATE OF BIRTH	AGE	M/F	HOME PHONE CELL PHONE
ADDRESS	CITY	STATE	ZIP
EMPLOYER	OCCUPATION	PHONE	
SPOUSE or PARENT (**If patient is a minor**)	RELATIONSHIP	PHONE	ALTERNATE PHONE
EMERGENCY CONTACT **not living with you**	RELATIONSHIP	PHONE	ALTERNATE PHONE
PCP/REFERRING PHYSICIAN	CITY **(IF OUT OF AREA)**	PHONE / FAX **(IF OUT OF AREA)**	
INSURANCE CARRIER	ID#	PHONE	
SUBSCRIBERS NAME	Subscribers Date of Birth	Subscribers Social Security #	

In the event your insurance information, including secondary insurance has changed please inform us immediately in order to verify eligibility, co-payments and/or deductibles. Failure to inform us of any changes can result in a delay of service and/or cancellation of appointments or scheduled procedures. We make every attempt to communicate up to date information regarding services provided and insurance requirements based on the information provided by you. Your insurance may pay all, some or none of your bill. Any remaining balance, deductible and co-payments are the patient's responsibility.

I hereby authorize Inland Empire Gastroenterology Medical Group, Inc. (IEGMG) to examine and provide medical treatment as needed. I authorize my insurance company to pay by check made out directly to Inland Empire Gastroenterology Medical Group. I assume full responsibility for any balance due. I authorize Inland Empire Medical Group, Inc to release any medical or personal information necessary for either medical care or in processing insurance claims. I understand it is my responsibility to know which hospital, emergency room, laboratory, radiology facilities, specialists and providers are covered under my insurance plan/s. It is Inland Empire Gastroenterology Medical Group's procedure to share Protected Health Information with labs, radiology, consulting physicians, hospitals and pharmacies as needed. We will only exchange the necessary Protected Health Information required in effort to better serve you.

I authorize IEGMG to share my health information with the following person/s, unless otherwise instructed:

I have read and understand the above information.

______________________________________ ____________________

Signature of Patient or Legal Representative (relationship) Date