

**ALBANY GASTROENTEROLOGY CONSULTANTS, P.C.**

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Deborah Randaisi, R.P.A.-C  
Patricia Nevinger, F.N.P.-C  
Philip Sternklar, R.P.A.-C

APPT. TIME: \_\_\_\_\_

APPT. DATE: \_\_\_\_\_

ACCT #: \_\_\_\_\_

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_ Apt #: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Social Security: xxx-xx- \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Race: American Indian or Alaska Native: \_\_\_ Asian: \_\_\_ Black or African American: \_\_\_ Native Hawaiian: \_\_\_ Pacific Islander: \_\_\_  
White: \_\_\_ Other: \_\_\_ Refused/Not Reported: \_\_\_

Ethnicity: Latino/Hispanic: \_\_\_ Not Latino/Hispanic: \_\_\_ Refused/Not Reported: \_\_\_ Preferred Language: \_\_\_\_\_

Email address: \_\_\_\_\_ Employer's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Contact: Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

**SPOUSE INFORMATION**

Name: \_\_\_\_\_ Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Address (if different than above): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

**INSURANCE INFORMATION**

PRIMARY Insurance: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Name of Policy Holder: \_\_\_\_\_ Policyholder's: Date of Birth: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

SECONDARY Insurance: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Name of Policy Holder: \_\_\_\_\_ Policyholder's: Date of Birth: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_ City: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Who Referred You? \_\_\_\_\_ City: \_\_\_\_\_ Phone #: \_\_\_\_\_

Any other practitioners to whom you would like records sent? (Name, Address, Phone Number)

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Authorization To Pay Benefits To Physician:** I hereby give authorization for payment of insurance benefits to be made directly to Albany Gastroenterology Consultants, P.C. for services rendered. I understand that I am fully responsible for all charges whether or not the charges are covered by insurance.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**Office Use Only:**

Payment: Cash \_\_\_\_\_

Check \_\_\_\_\_

Credit Card \_\_\_\_\_