

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

**PATIENT INFORMATION**

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

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

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

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

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

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

**SPOUSE INFORMATION**

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

Address (if different than above): \_\_\_\_\_

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

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

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**INSURANCE INFORMATION OF POLICY HOLDER**

PRIMARY Insurance: \_\_\_\_\_ Address: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_ Name of Policy Holder: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Employer: \_\_\_\_\_

SECONDARY Insurance: \_\_\_\_\_ Address: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_ Name of Policy Holder: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Employer: \_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_ City: \_\_\_\_\_ Phone #: \_\_\_\_\_

Who Referred You? \_\_\_\_\_ City: \_\_\_\_\_ Phone #: \_\_\_\_\_

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

**Authorization for Voicemail Usage for PHI**

I hereby give permission to leave a message on my voicemail concerning my personal health information.

\_\_\_\_\_ (decline option)

I further understand that this permission to communicate my personal health information will be in effect until I request, in writing, to have this option terminated.

\_\_\_\_\_  
Patient Signature and Date

\_\_\_\_\_  
Witness Signature and Date