



# GASTROINTESTINAL & LIVER CONSULTANTS

## REGISTRATION FORM

Today's date	Referring Physician	Primary Doctor
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### PATIENT INFORMATION

Patient's Name (Last, First):	Date of Birth:	Marital status:
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Single / Married / Separated / Divorced / Widowed

Gender:	Cell Phone #:	Home Phone #:	Preferred Language:
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M  F

English / Spanish / Other: \_\_\_\_\_

Street address:	Social Security no.:
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City:	State:	Zip Code:	E-mail Address:
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### EMERGENCY CONTACT

Name of a friend or relative:	Relationship with patient:	Telephone Number:
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### PHARMACY INFORMATION

Name of the Pharmacy:	Pharmacy Address
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City:	State:	Zip Code:
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### AUTHORIZATION TO RELEASE INFORMATION TO FAMILY/FRIENDS OR OTHERS

*I authorize GILC to release any information regarding my treatment, including lab results, x-rays, and medical records, to the following individuals/entities (The office may not release information or records to the names individual's entities unless you identify them here):*

N/A – Not Applicable

Full Name	Relationship to Patient
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1.

2.

### AUTHORIZATION TO PAY

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to **Gastrointestinal and Liver Consultants**. I understand that I am financially responsible for any balance, co-pay, and deductible. I also authorize **Gastrointestinal and Liver Consultants** or insurance companies to release any information required processing my claims.

\_\_\_\_\_  
**Patient or Guardian Signature**

\_\_\_\_\_  
**Date**