MID-SOUTH GASTROENTEROLOGY GROUP

Phillip R. Bowden, M.D., P.A.

Date _____

Referral Source ☐ Yellow Pages ☐ Newspaper ☐ Radio ☐ Physician/Clinic _____ ☐ Other _____

PATIENT REGISTRATION FORM - Please Print Clearly

Referring Physician _____ Primary Care Physician _____

PATIENT INFORMATION

Name _____ (LAST / FIRST / MIDDLE) Social Security No. _____

Address _____ Phone No. (____) _____

City _____ State _____ Zip _____

Date of Birth _____ Age _____ Sex ☐ FEMALE ☐ MALE Race _____ Marital Status ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

Mobile No. _____ Email _____

Employer _____ Occupation _____

Employer Address _____ Phone No. (____) _____

City _____ State _____ Zip _____

INSURANCE INFORMATION

Primary Insurance Company Name _____ Group No. _____

I.D. No. _____ Subscriber _____ (LAST / FIRST / MIDDLE)

Insurance Company Address _____ City _____ State _____ Zip _____

Insured's Relationship to Patient _____ Insured Date of Birth _____

Secondary Insurance Company Name _____ Group No. _____

I.D. No. _____ Subscriber _____ (LAST / FIRST / MIDDLE)

Insurance Company Address _____ City _____ State _____ Zip _____

Insured's Relationship to Patient _____ Insured Date of Birth _____

EMERGENCY INFORMATION

Relative or Friend _____ Relationship _____
(NOT LIVING WITH PATIENT)

Address _____ City _____ State _____ Phone No. (____) _____

RESPONSIBLE PARTY INFORMATION

Name _____ Relationship to Patient _____

Address _____ City _____ State _____

Zip _____ Phone No. (____) _____ Social Security No. _____ Date of Birth _____

Spouse's Name _____ Date of Birth _____

Responsible Party's Employer _____ Phone No. (____) _____ Fax No. (____) _____

Employer Address _____ City _____ State _____ Zip _____

ASSUMPTION OF FINANCIAL RESPONSIBILITY

In order to obtain services from the physicians and staff of the Mid-South Gastroenterology Group (MSGG) and/or Philip R. Bowden, MD, PA (PRB), the undersigned agrees as follows:

1. I consent to treatment by any or all associates of MSGG and/or PRB.
2. The responsible party shall be financially responsible for all medical services and supplies provided by any physician, nurse or technician of MSGG and/or PRB.
3. The responsible party hereby assign(s) to MSGG and/or PRB all of the rights, title and interest in and to any insurance proceeds payable for treatment rendered to the patient and further agree(s) to deliver all checks and drafts received from insurance companies, properly endorsed to MSGG and/or PRB.
4. MSGG and/or PRB is hereby authorized and requested to furnish to any insurance company, other third party payor, hospital or physician any and all information it may have concerning the patient named above including, but not limited to, medical history, reports, consultations, prescriptions, treatment, including x-rays, and any and all other requested information and/or documentation pertaining to such patient. A photostatic copy of this authorization shall be considered as valid and effective as the original. This document does not expire.
5. If more than one person signs below, each is jointly and severally liable with the other. The undersigned executes this agreement for the purpose of inducing MSGG and/or PRB, to provide medical services and supplies to patient named above.
6. This authorization includes the release of information to MSGG and/or PRB.
7. Patient is responsible for all fees associated with missed appointments, returned checks, collection fees and/or attorney fees.

_____ PATIENT'S SIGNATURE DATE

_____ RESPONSIBLE PARTY'S SIGNATURE DATE