

NAME OF YOUR PHYSICIAN

- | | | |
|---|--|---|
| <input type="checkbox"/> Edward J. Wolf, M.D, FACP | <input type="checkbox"/> Edward D. Zimmerman, M.D. | <input type="checkbox"/> Lester Bowser, M.D. |
| <input type="checkbox"/> Todd D. Heller, M.D., FACP, FACC | <input type="checkbox"/> Steven Fleisher, M.D. | <input type="checkbox"/> Ethan Dubin, M.D. |
| <input type="checkbox"/> Gerald A. Hofkin, M.D., FACP | <input type="checkbox"/> Lila Tarmin, M.D., FACP | <input type="checkbox"/> Jeffrey Schwartz, M.D. |
| <input type="checkbox"/> Loc T. Le, M.D. | <input type="checkbox"/> Michael S. Siuta, M.D. | <input type="checkbox"/> Alan Rosen, M.D. |

PLEASE PRINT

TODAY'S DATE _____

LAST NAME _____ FIRST NAME _____ MI _____

ADDRESS _____ CITY _____

STATE _____ ZIP CODE _____ CELL PHONE _____

HOME PHONE _____ WORK PHONE _____ EMAIL _____

 SEX M F SOCIAL SECURITY # _____ DATE OF BIRTH _____

EMPLOYER NAME _____ OCCUPATION _____

 MARITAL STATUS SINGLE MARRIED OTHER

PRIMARY CARE PHYSICIAN NAME, ADDRESS & PHONE # _____

CARDIOLOGIST NAME & PHONE # _____

EMERGENCY CONTACT _____

PHONE # _____ CELL PHONE # _____

 PATIENT'S RELATIONSHIP TO INSURED SELF SPOUSE CHILD OTHER

COMPLETE ONLY IF PATIENT'S RELATIONSHIP TO INSURED IS NOT SELF:

INSURED'S NAME _____

INSURED'S ADDRESS AND PHONE # _____

INSURED'S DATE OF BIRTH _____ INSURED'S SOCIAL SECURITY # _____

INSURED'S EMPLOYER _____ INSURED'S WORK PHONE # _____

PAYMENT OF BENEFITS

I request the direct payment of authorized medical benefits to be made to Woodholme Gastroenterology Associates, P.A./The EndoCentre for any services furnished to me by the physicians or laboratory of Woodholme Gastroenterology Associates, P.A./The EndoCentre. I authorize any holder of medical information about me to release this information as necessary to process my claims or meet legal requirements. I permit a copy of this authorization to be used in place of the original. This assignment will remain in effect until revoked, in writing. I understand that because these services were performed for me or my legal dependent, I am financially responsible for all charges incurred whether or not paid by the insurance carrier.

 Patient's/Guardian's Signature

 Date