birmingham gastroenterology

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Birmingham, AL 35209
Phone: 205-271-8000 Fax: 205-329-7444

PATIENT INFORMATION

LAST NAME:	FIRST NAME:			MIDDLE NAME:
PRIMARY PHONE:	CELL PHONE:		SEX: F ☐ M ☐	BIRTH DATE:
SSN:	STREET ADDRESS:			
CITY:	STATE:	ZIP:	EMAIL ADDRESS:	

REFERRING PHYSICIAN INFORMATION

PHYSICIANS NAME:	**NPI:**	
OFFICE CONTACT:		
PHONE:	**FAX:**	**EMAIL ADDRESS:**

INSURANCE POLICY HOLDER INFORMATION

POLICY HOLDER'S RELATIONSHIP TO PATIENT: ☐SELF ☐PARENT ☐SPOUSE ☐CHILD ☐ OTHER	LAST NAME:		FIRST NAME:
SEX: F ☐ M ☐	BIRTH DATE:		PRIMARY PHONE:
PRIMARY INSURANCE CARRIER:	POLICY #:	GROUP #:	EFFECTIVE DATE:
SECONDARY INSURANCE CARRIER:	POLICY #:	GROUP #:	EFFECTIVE DATE:

☐ Procedure(s) Ordered

☐EGD ☐Colonoscopy ☐Esophageal Manometry	☐EUS ☐ERCP ☐Capsule Endoscopy	☐Halo ☐Hemorrhoid Banding/HET	☐Flexible Sigmoidoscopy ☐Other:_____

Diagnosis: _____

Please indicate gastroenterologist requested, if applicable: _____ ☐ **No preference**

☐ Patient to be scheduled for office visit

Reason for appointment: _____

Please indicate gastroenterologist requested, if applicable: _____ ☐ **No preference**