PERSONAL INSURANCE INFORMATION

Estrella Gastroenterology

Last name	First name	Date of birth / /	Social Sec. # - -
Address	City	State _AZ	Zip _____
Home phone	Cell phone	Business phone	
E-MAIL _____ @ _____			
Marital Status: __ Married __ Single __ Divorced __ Widowed __ Separated		Gender __ male __female	

INSURANCE INFORMATION (Must be filed out completely for verification purposes) **____ Check HERE if you have NO insurance**

Primary insurance company	Policyholder name	Policyholder DOB	Patient relationship to insured __Self __Spouse __ Child __ Other
Policy #	Group #		
Secondary insurance company	Policyholder name	Policyholder DOB	Patient relationship to insured __Self __Spouse __ Child __ Other
Policy #	Group #		

We required to ask this question about your race: __ White or Caucasian __ Hispanic or Latino __ Black Hispanic or Latino __ Black or African American

__American Indian or Alaska Native __ Native Hawaiian or Other Pacific Islander __ Asian __ Other __ I prefer to not answer

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I authorize the release and/or discussion of my health information with the following persons.

Name_____ Relationship _____ Phone number _____

Name_____ Relationship _____ Phone number _____

Name_____ Relationship _____ Phone number _____

__ Do not discuss my information with anyone.

PHARMACY

Name of Pharmacy	Address:	Phone number

EMERGENCY CONTACT

Name_____ Relationship _____ Phone number _____

I declare that the above answers and statements are true and correct to the best of my knowledge. I hereby acknowledge that I have read this entire section front and reverse, and agree to of all the terms herein.

x_____ _____

Signature of patient, responsible party Date

NEW PATIENTS: Please indicate how you heard about us. Thank you!

☐ Physician ☐ Friend ☐ Word of mouth ☐ Insurance company ☐ Internet ☐ Other: