PATIENT REGISTRATION FORM
ALL ISLAND GASTROENTEROLOGY & LIVER ASSOCIATES
Harold Lipsky, M.D. Pradeep Bansal, M.D.

PATIENT INFORMATION
If an interpreter is needed please advise our Front Desk Staff upon arrival

Patient Full Name ____________________
Please Print **Last** **First** **MI** **Social Security #**

Permanent Address____________________

City: ____________________**State:**____________________**Zip Code:**____________________

Home Phone #____________________**Cell Phone**____________________ **EMAIL Address:** ____________________

Sex: [ ] M [ ] F **Date of Birth**____________________**Age:**____________________**Preferred Language:**____________________

Race: **please circle** **AFRICAN AMERICAN** **CAUCASIAN** **HISPANIC** **OTHER**

Pharmacy Name: ____________________**Address:**____________________**Phone #:**____________________

Smoking Status: **please circle** **NEVER** **PAST** **CURRENT**

HT: ____________________**WT:**____________________**BLOOD PRESSURE:** ____________________

Employer: ____________________**Work Phone #**____________________

Spouse Name: ____________________ **Spouse Date of Birth:** ____________________

Emergency Contact: ____________________ **Phone # (_____)**____________________

Referring Physician: ____________________ **Primary Care Physician:** ____________________

Phone#____________________**Fax#**____________________ **Phone#**____________________**Fax#**____________________

INSURED'S INSURANCE INFORMATION – PRIMARY

Insurance Carrier: ____________________

Insured Name: ____________________**Insured DOB:**____________________

Insurance ID #:____________________**Policy #:**____________________**Group#**____________________

INSURED'S INSURANCE INFORMATION – SECONDARY

Insurance Carrier: ____________________

Insured Name: ____________________**Insured DOB:** ____________________

Insurance ID #:____________________**Policy #:**____________________**Group#**____________________

ASSIGNMENT OF BENEFITS & AUTHORIZATION OF RELEASE OF INFORMATION:

I (the Patient as noted above) hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier (s), including Medicare, Private Insurance and any other Health/Medical plan to issue payment checks directly to **ALL ISLAND GASTROENTEROLOGY & LIVER ASSOCIATES** for any medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any, I understand that I am **RESPONSIBLE** for any amount not covered by my insurance.

I hereby authorize the physicians of **ALL ISLAND GASTROENTEROLOGY & LIVER ASSOCIATES** to furnish and/or release any information necessary to any of my other doctors and all relevant insurance carriers concerning my illness and treatments, to process my insurance claim acquired in the course of my examination or treatment, and to allow a photocopy of my signature to be used to process my insurance claim for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from the physicians of **ALL ISLAND GASTROENTEROLOGY & LIVER ASSOCIATES** on behalf of myself and/or by the referral of my primary care and referring physician, and understand that by making this request, I become fully **FINANCIALLY RESPONSIBLE** for any and all charges incurred in the course of the treatment authorized. **I further understand that fees (deductibles, co-pay) are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon services rendered.** A photocopy of this assignment is to be considered as valid as the original.

ATTESTATION:
I have had the opportunity to review the Practice's Notice of Privacy (HIPAA), Patient's Rights & Responsibilities Policy, Patient Safety Statement and MD Biographical information (located in a binder in the waiting room).

DISCLOSURES: (1) The physicians of All Island Gastroenterology & Liver Associates, P.C. have a financial interest in Meadowbrook Endoscopy Center, 865 Merrick Avenue, Westbury, NY 11590. (2) For your convenience and preference, a non-participating ancillary care provider may be involved in your treatment and care. If you have any questions or would like to locate an in-network provider, please contact your insurance carrier's customer service department. Your signature below will serve as confirmation that you are aware that a non-participating provider may be recommended to perform a service or procedure and that you have been given adequate notice to contact your insurance company for alternate providers of care.

Patient / Responsible Party – Signature: ____________________**Date**:____________________

Responsible Party (if not patient) Print Full Name: ____________________