

La Jolla Gastroenterology Medical Group, Inc.

9850 Genesee Ave, Suite 820, La Jolla, CA 92037 (858) 453-5200

My appointment today is with Dr. Lenz

Patient _____
(Last Name, First Name, MI)

Birthdate ____/____/____ **Age** _____

Address _____
(Mailing Address, including apt #)

Gender ___M ___F **Marital Status** _____

City _____

Social Security Number _____

State _____ **Zip Code** _____

E-Mail address _____

Home Phone (_____) _____

Cell Phone (_____) _____

Employer _____

Work Phone (_____) _____

Emergency Contact Name _____

Phone Number _____

Insurance Carrier Primary _____

Secondary _____

Referred By _____

Primary Physician _____

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Authorization to pay benefits to physician: I hereby authorize payment of medical and/or surgical benefits directly to La Jolla Gastroenterology Medical Group, Inc. for services described on the insurance claim forms. I realize that the insurance payment may not represent full payment for services rendered and I will be responsible for the balance due including, but not limited to, deductibles, co-pays, co-insurances, and services not covered under my plan. It is my responsibility to know the coverage of benefits for my insurance policy. I agree to remit payment within 30 days of receipt of a statement and understand that La Jolla Gastroenterology Medical Group charges \$5.00 for each past due statement generated for any unpaid balances.

Authorization to release information: I hereby authorize the release of any medical or other information necessary to my insurance company to process claims for services rendered.

HIPAA Policy: I hereby acknowledge receipt of the Notice of Privacy Practices of La Jolla Gastroenterology.

Patient Signature

Date