Bruce A. Salzberg M.D., F.A.C.G
Atlanta Gastroenterology Specialists PC

Patient Number ______________

Patient Registration

Date: ______________

Patient Information

Social Security # ______________________________

First Name______________________Middle Initial___

Last Name ______________________________

Date of Birth__/__/___ Gender: Male Female

Driver's License #______________________State ____

☐ Employed FT Employed PT Student FT
☐ Other ________________________

Employer______________________________

Employer Address ______________________

Suite________City____________________

State________Zip____________________

Employer Phone ______________________

Referring Physician ______________________

Primary Address:
____

City_______State____________Zip_______

Email Address:
____

Phone Numbers – Important – Please fill out.

Home Phone_________________

Work Phone _________________

Cell Phone _________________

How did you hear of us?

Insurance Information -- Please provide your insurance cared to the receptionist

☐ Commercial Medicaid Medicare Worker's Compensation Other ______________________

Insurance Company:_______________________Policy #_______________Group #____________________

Insured / Card Holder's Name__________________________Relationship to Patient ___________________

Insured D.O.B. ___/___/___ SSN#_____________________Phone____________________

Employer City / State___________________Phone_______________

Secondary Insurance Information -- Please provide your insurance cared to the receptionist

☐ Commercial Medicaid Medicare Worker's Compensation Other _____________________

Insurance Company:_______________________Policy #_________________ Group # _______________

Insured / Card Holder's Name___________________________ Relationship to Patient ________________

Insured D.O.B.___/___/___SSN#________________________Phone ____________________

Employer City / State______________________Phone ______________________

Pharmacy Information

Pharmacy Name______________________________ Phone _______________

Address______________________________ City__________________State______Zip ________

Emergency Contact

Full Name (First, Middle,Last __________________________Phone______________________

Relationship to Patient__________________________Gender Male Female

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

____
Signature (Patient or Parent, if minor) Date

____
Signature (Patient or Parent, if minor) Date