

**North Valley Gastroenterology**  
**18404 N Tatum Blvd Suite 102**  
**19636 N 27<sup>th</sup> Ave Suite 308**  
**9327 N 3<sup>rd</sup> St Suite 202**  
**Phone: 602-485-7475**  
**Fax: 602-485-7492**

**Joseph Fares, MD**  
**Juan Teran, MD**  
**Thusha Nathan, MD**  
**David Payton, PA**

### **Patient Registration**

#### **PATIENT:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Initial: \_\_\_\_\_  
Address: \_\_\_\_\_ Apt. Or Space No.: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Marital Status: M/S/D/W  
Social Security Number: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Gender: M/F  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Primary Doctor: \_\_\_\_\_ Referred By: \_\_\_\_\_  
Pharmacy Name \_\_\_\_\_ Pharmacy Cross Streets: \_\_\_\_\_

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#### **RESPONSIBLE PARTY:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Initial: \_\_\_\_\_  
Address: \_\_\_\_\_ Apt. Or Space #: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Gender: M/F  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Address: \_\_\_\_\_ State/Zip: \_\_\_\_\_

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#### **EMERGENCY CONTACT:**

Full Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Telephone: \_\_\_\_\_

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#### **INSURANCE INFORMATION:**

Primary Insurance: _____	Secondary Insurance: _____
Address: _____	Address: _____
City/State/Zip: _____	City/State/Zip: _____
Telephone: _____	Telephone: _____
Insured ID #: _____	Insured ID #: _____
Group #: _____	Group #: _____
Policy Owner Name: _____	Policy Owner Name: _____
DOB: _____ Relationship: _____	DOB: _____ Relationship: _____
Policy Owner Social Security #: _____	Policy Owner Social Security #: _____
Employer Name: _____	Employer Name: _____

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#### **AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF MEDICAL BENEFITS:**

I hereby authorize North Valley Gastroenterology to treat the above named patient. I authorize the release of medical information necessary to process insurance claims concerning my illness and treatment. Photocopies are valid as original. I authorize payment of medical benefits to be paid directly to North Valley Gastroenterology. I understand that I am financially responsible for any amounts not covered by my health insurance.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_