HIGH DESERT GASTROENTEROLOGY, INC.

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Ridgecrest, CA 93555
(760) 446-2196

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Ridgecrest, CA 93555
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20211 Valley Blvd.
Tehachapi, CA 93561
(661) 823-8350

LONE PINE
510 East Locust St.
Lone Pine, CA 93545
(760) 876-5700

PATIENT'S ACCOUNT #	GUARANTOR	CHART NUMBER	CATEGORY
NAME (LAST, FIRST INITI.)	HOME PHONE NO.	DOB	DL #
ADDRESS	CITY	STATE	ZIP CODE
SOCIAL SECURITY NUMBER	SEX (M/F)	MARITAL STATUS	ETHNICITY
OCCUPATION	EMPLOYER (IF RETIRED FROM WHERE?)	NATURE OF BUSINESS	
EMPLOYER ADDRESS	CITY	STATE	ZIP CODE
EMPLOYER PHONE NO.	REFERRAL	IN CASE OF EMERGENCY CONTACT PERSON AND PHONE NO.	
SPOUSES'S NAME (OR GUARANTOR)	HOME PHONE NO.	DOB	DL#
ADDRESS	CITY	STATE	ZIP CODE
SOCIAL SECURITY NUMBER	SEX (M/F)	MARITAL STATUS	ETHNICITY
OCCUPATION	EMPLOYER (IF RETIRED FROM WHERE?)	NATURE OF BUSINESS	EMPLOYER PHONE NO.
EMPLOYER ADDRESS	CITY	STATE	ZIP CODE
PRIMARY INSURANCE INFO. PLEASE PROVIDE COPY OF INSURANCE CARD	INSURANCE NAME		
INSURANCE ADDRESS			
INSURED'S NAME	SUBSCRIBER NO./MEDICARE NO.	GROUP NO.	
SECONDARY INSURANCE INFO. PLEASE PROVIDE COPY OF INSURANCE CARD	INSURANCE NAME		
INSURANCE ADDRESS			
INSURED'S NAME	SUBSCRIBER NO./MEDICARE NO.	GROUP NO.	

All Professional services are charged to the Patient. Necessary forms will be completed to expedite Insurance Carrier payments. However, the patient is responsible for all fees, regardless of Insurance Coverage. We appreciate payment for services when rendered unless other arrangements have been made in advance.

INSURANCE AUTHORIZATION AND ASSIGNMENT (Please read and sign)

I hereby authorize HIGH DESERT GASTROENTEROLOGY, INC to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the Physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Date _____ Signature _____