

CENTER for DIGESTIVE DISEASES, P.A.

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PLEASE FILL OUT THIS FORM COMPLETELY

Name: _____ S.S. # _____ - _____ - _____

Date of Birth: ____/____/____ Sex: F M Marital Status: S M W Sep D Spouse's Name: _____

Home Address: _____
Apt# Street City State Zip

Home Phone # (____) _____ Work Phone #(____) _____ Cell: (____) _____

Primary Doctor: _____ Phone# _____

Referring Doctor: _____ Phone# _____

Emergency contact: _____
Name Relationship Phone

Primary Insurance: Insured Person: Self Spouse Parent

Insurance Co. Name: _____

Claim Address: _____
Street City State Zip

Subscriber's Name: _____ Subscriber's DOB: _____

I.D.#: _____ Group: _____ Plan: _____

Subscriber's Employer information (Employed by/Retired from): _____
Employer/Business Name

Address City State Zip

Secondary Insurance: Insured Person: Self Spouse Parent

Insurance Co. Name: _____

Claim Address: _____
Street City State Zip

Subscriber's Name: _____ Subscriber's DOB: _____

I.D. #: _____ Group: _____ Plan: _____

Subscriber's Employer information (Employed by/Retired from): _____
Employer/Business Name

Address City State Zip

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

MEDICARE PATIENTS:

Name of Beneficiary (Patient) _____

I request that payment of authorized Medicare benefits be made on my behalf to **Center for Digestive Diseases, P.A.** for any services furnished me by that practice. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I hereby authorize Medicare to furnish to the above named practice/physician any information regarding my Medicare claim under Title XVIII of the Social Security Act.

ALL PATIENTS:

I hereby authorize **Center for Digestive Diseases, P.A.** to apply for benefits on my behalf for covered services rendered by the practice/physician or by physician's order. I request that payment from my insurance company be made directly to **Center for Digestive Diseases, P.A.** I authorize the release of any medical information necessary to process this claim. I permit a copy of this assignment to be used in the place of the original. This assignment will remain effective until revoked by me in writing.

I understand I am financially responsible for any balance not covered by my insurance carrier.

Date ____/____/____ Signature (Patient, Parent or Guardian): _____