FRESNO GASTROENTEROLOGY

A MEMBER OF COMMUNITY FOUNDATION MEDICAL GROUP & PART OF SANTÉ HEALTH FOUNDATION.

7095 N. Chestnut #101, Fresno, CA 93720
Ph. (559) 323-8200 • Fax (559) 323-9200

7055 N. Maple Ave. #106 • Fresno, CA 93720
Ph. (559) 297-2259 • Fax (559) 297-2269

PATIENT INFORMATION
(Please Print)

FOR THE OFFICE STAFF TO COMPLETE:

FC: _____

PCP: _____

HCL: _____

LAST NAME: _____ FIRST NAME: _____ M.I.: ____

ADDRESS: _____
(Street) (City) (State) (Zip)

DATE OF BIRTH: _____ SEX: ☐ MALE ☐ FEMALE HOME PHONE: _____

SOCIAL SECURITY #: _____ WORK: _____ PHONE CELL: _____

NEAREST RELATIVE NOT LIVING WITH YOU (RELATIONSHIP): _____ TELEPHONE: _____

REFERRING DOCTOR: _____ TELEPHONE: _____

SUBSCRIBER NAME: _____ RELATIONSHIP TO SUBSCRIBER: _____

PATIENTS'S EMPLOYER NAME: _____ TELEPHONE: _____

SPOUSE'S NAME: _____

I AUTHORIZE FRESNO GASTROENTEROLOGY TO DISCUSS MEDICAL INFORMATION RELATED TO MY CARE WITH THE FOLLOWING FAMILY MEMBERS/INDIVIDUALS.

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

RESPONSIBLE PARTY INFORMATION
(GUARANTOR)

LAST NAME: _____ FIRST NAME: _____ M.I.: ____

ADDRESS: _____
(Street) (City) (State) (Zip)

HOME PHONE: _____ OCCUPATION: _____

SUBSCRIBERS EMPLOYER NAME: _____

ADDRESS: _____

SUBSCRIBER SS #: _____

PATIENT'S RELATIONSHIP TO GUARANTOR: 01 ☐ SAME 02 ☐ HUSBAND 03 ☐ WIFE 04 ☐ SON 05 ☐ DAUGHTER 06 ☐ STEPCHILD

OTHER: _____

HOW DID YOU HEAR ABOUT OUR OFFICE?: _____

DISCLOSURE: Dr. Ajit Arora, Dr. John Abdulian and Dr. Stephen Davis have a financial interest at the Central California Endoscopy Center.

INSURANCE CLAUSE: I understand that if this or any other visit precedes the effective date of my insurance; or is not covered by my insurance, I will be held responsible for all fees incurred as a result of this and any subsequent visit.

FINANCIAL DISCLOSURE: Fresno Gastroenterology is a member of Community Foundation Medical Group (CFMG) and I may receive a bill from CFMG for services provided by Fresno Gastroenterology and/or the group's providers

TREATMENT CONSENT: I hearby give consent for medical or surgical treatment to Dr. Ajit Arora, Dr. John Abdulian and Associates to care for myself or I am duly authorized by the patient as his/her general agent to give consent for such treatment.

ASSIGNMENT OF PAYMENT OF BENEFITS: I hereby authorize payment directly to Ajit Arora, MD., Inc. of any medical or surgical benefits payable to me under the conditions of my policy for services rendered.

RELEASE OF INFORMATION: I hereby give consent to release to authorized persons of financial and medical information concerning care and treatment and changes therefore as may be required to complete all claims for benefits.

_____ _____

Pt. Signature / Pt. Representative Signature Date