Steven Sangha, M.D.
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