SANTA BARBARA GASTROENTEROLOGY CONSULTANTS MEDICAL GROUP
2403 CASTILLO ST. SUITE 201 | SANTA BARBARA, CA 93105
PHONE: (805)682-3585 | FAX: (805)682-4072

Patient Information

Last Name	First Name	Middle Name

Date of Birth	SSN	□ Female □ Male

Home phone (□ Preferred number)	Cell Phone (□ Preferred number)	Work Phone (□ Preferred number)

Address	City	Zip Code	State

Email address	Preferred Language (Leave blank to decline) □ English □ Spanish □ Other _____

Race (Leave blank to decline)	Ethnicity (Leave blank to decline)
□ Black/African American □ White/Caucasian □ American Indian/Alaska Native □ Other □ Hawaiian/Pacific Islander □ Asian	□ Hispanic or Latino □ Not Hispanic or Latino

Marital Status	Spouse Name	Spouse Date of Birth

Emergency Contact

Name	Relationship to patient	Phone

Physician/Pharmacy Information

Primary Care Doctor (and phone number, if known)	Preferred Pharmacy (please include location)

Insurance Information

Primary Insurance	Secondary Insurance (if applicable)

PLEASE PROVIDE COPIES OF INSURANCE CARDS AND INFORMATION WITH THIS FORM

Assignment and Release of Benefits

I hereby assign all medical and/or surgical benefits, to include Major Medical Benefits to which I am entitled, including Medicare, private insurance, and any other health plan to Santa Barbara Gastroenterology Consultants. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release medical information to secure payment.

Signature	Date