GATGI
Gastroenterology Associates of Tidewater

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Walid F. Makdisi, MD
Brian M. Sullivan, MD
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Rene J. Rivera, MD
Jeremy P. Domanski, MD

PATIENT INFORMATION

Patient Name: (First) (M.I). (Last) :
Street Address:
City: State: Zip Code:
Home Phone: ( ) Work Phone:
Cell Phone: ( ) E-mail Address: ☐ Web enabled
Social Security Number: Date of Birth:
Sex: (please check one box) ☐ M ☐ F Ethnicity: Language
Marital Status: (please check one box) ☐ Married ☐ Single ☐ Divorced ☐ Widowed
Primary Care Physician Name: Phone Number ( )
Referring Provider Name: Phone Number ( )

OCCUPATION INFORMATION

Employer: Occupation:
Street Address:
City: State: Zip Code:

EMERGENCY INFORMATION (Next of Kin)

Name: Relationship:
Home Phone: ( ) Work Phone: ( )
Pharmacy: **Phone Number:**
City: State

INSURANCE INFORMATION

Primary Insurance Name:
ID Number: Group Number:
Name of Insured: Relationship to Insured:
Insured SSN: Insured Date of Birth:
Secondary Insurance Name:
ID Number: Group Number:
Name of Insured: Relationship to Insured:
Insured SSN: Insured Date of Birth:

AUTHORIZATION FOR TREATMENT & ASSIGNMENT OF BENEFITS

This will authorize the filing of any insurance in force and the direct payment to Gastroenterology Associates of Tidewater of any amount due on my claim under the above stated policy. I understand that my insurance policy is a contract between me and my insurance company and that I am financially responsible to Gastroenterology Associates of Tidewater for non-payment of any fees not covered by insurance. I understand and agree to pay in full any balance due after an insurance payment or to make payment arrangements with Gastroenterology Associates of Tidewater. In consideration of service rendered, the undersigned patient, spouse, and/or responsible party agree that each will be jointly and severally liable and guarantee payment for any or all services rendered. It is further agreed that the undersigned patient, spouse, and/or responsible party agrees to pay all cost of collections including attorney's fees in the amount of 33-1/12 % plus court cost and any interest allowable by law, if incurred. Any unpaid balance will be subject to a finance charge of 1.5% per month (18% APR) commencing 60 days from the date of service. I hereby authorize the release of any medical information necessary to process claims.

Patient Signature: Date Signed:

Norfolk Office
155 Kingsley Lane, Suite 300
Norfolk, Virginia23505
(757) 889-6800
Fax (757) 547-0145

Virginia Beach Office
5701 Cleveland Street,Suite 100
Virginia Beach, VA23462
(757) 547-0798
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Chesapeake Office
112 Gainsborough Square, Suite 200
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