Natwarlal V. Ramani, M.D.
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GI ASSOCIATES OF DELAWARE, P.A.
742 S. Governors Avenue, Ste 3, Dover, DE 19904

Patient's Name: _____,_____ **Sex**: **M / F**
Last Name **First Name** **Middle**

_____ **Marital Status**: S☐ M☐ W☐ D☐ Sep☐ **Birth Date**: _____/_____/_____ **Race**:_____
Social Security Number

Address: _____
Street **City** **State** **Zip**

Home Phone: _____ **Cell Phone**: _____ **Work Phone**: _____

Email: _____ **Referred by**: _____ **Family Dr.**: _____

INSURANCE INFORMATION

Primary Insurance: _____ **Policy #**: _____

Secondary Insurance: _____ **Policy #**: _____

Medication Insurance: _____ **Policy #**: _____

Insured Person (If other than patient)

Name: _____ _____
Last Name **First Name** **Middle** **Social Security Number**

Date of Birth: _____/_____/_____ **Relationship**: _____ **Phone #**: _____
Month Date Year

EMERGENCY CONTACT

Spouse Name: _____ **Home #:**_____ **Work #:** _____ **Cell #:** _____

Emergency Contact: _____ **Phone #**: _____ **Relation**: _____
(If other than spouse) **(If possible, provide phone # different than yours)**

PHARMACY INFORMATION

Pharmacy Name: _____ **Location:** _____ **Phone #:** _____

EMPLOYMENT INFORMATION

Employer Name: _____ **Phone #**: _____

Address: _____ **Occupation**: _____

AUTHORIZATION / PROMISSORY NOTE

I authorize my doctor to bill my insurances for all services rendered and release any required information.
I promise to pay any co-pay, deductible, coinsurance, or any patient liability not covered by insurance.
I authorize payment of the medical benefits directly to the doctor for services rendered.
I understand that I will be responsible for paying a $15 late fee if turned over to a collection agency and a 40% collection fee and any legal fees if sent to National Collection Bureaus for collection of any debt.
I understand I will be discharged from this practice as a patient if I miss three consecutive appointments.

Patient/Guarantor Signature: _____ **Date**: _____/_____/_____
Month Date Year

HIPAA – I acknowledge that I have been provided the office's Notice of Privacy Practices.

I AUTHORIZE _____**, Birth Date:** _____**, Relationship:** _____ **to discuss and receive my health information. This authorization will be valid until revoked by me in writing.**

Patient/Guarantor Signature: _____ **Date**: _____/_____/_____
Month Date Year