# FRESNO GASTROENTEROLOGY

*A MEMBER OF SANTÉ FOUNDATION MEDICAL GROUP*
*& PART OF SANTÉ HEALTH FOUNDATION*

7095 N. Chestnut #101, Fresno, CA 93720
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## PATIENT INFORMATION
(Please Print)

FOR THE OFFICE STAFF TO COMPLETE: FC:

PCP:_____

HCL: _____

MRN:_____

LAST NAME:_____FIRST NAME:_____M.I.: _____

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

DATE OF BIRTH:_____SEX: ☐ MALE ☐ FEMALE SOCIAL SECURITY #:_____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORECED

HOME PHONE:_____ CELL PHONE:_____ WORK PHONE:_____

EMERGENCY CONTAT NAME:_____ PHONE:_____RELATIONSHIP_____

PATIENT'S EMPLOYER NAME:_____TELEPHONE:_____ OCCUPATION_____

REFERRING DOCTOR:_____TELEPHONE:_____

(GUARANTOR)

## RESPONSIBLE PARTY INFORMATION

LAST NAME:_____FIRST NAME:_____M.I.: _____

SUSCRIBERS SOCIAL SECURITY:_____ SUSCRIBERS DOB_____PHONE:_____

SUSCRIBERS EMPLOYER_____ ADDRESS_____PHONE_____

RELATIONSHIP TO SUSCRIBER

☐ SELF
☐ SPOUSE
☐ CHILD
☐ DOMESTIC PARTNER

**DISCLOSURE:** Dr. Ajit Arora, Dr. John Abdulian, Dr. Jonathan Myers 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 self 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