Treasure Valley Gastroenterology Specialists
Raquel Croitoru, M.D.
Board Certified Gastroenterology
Fellow American College of Gastroenterology

PATIENT INFORMATION

Date Completed: _____

Name: _____

Date of Birth: _____ **Age:** _____ **Sex:** _____ **Marital Status:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

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

SS#: _____ **Driver License #:** _____ **State:** _____

Employer: _____ **Occupation:** _____

Address: _____ **Phone:** _____

Spouse or Responsible Party: _____

Date of Birth: _____ **SS#:** _____ **Employer:** _____

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

In Emergency Please Notify: _____

Address: _____ **Phone:** _____

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

Primary Care Doctor: _____ **Phone:** _____

Fax: _____

AS A COURTESY we will bill your primary and secondary insurance carrier if you provide **ALL** necessary information (such as insurance cards and/or completed and signed claim forms if your carrier requires it and their **CORRECT** billing address). Co-pays and share of cost are collected for each visit. **A $35.00 FEE WILL BE CHARGED FOR ALL RETURNED CHECKS.**

SIGNATURE OF PATIENT OR GUARDIAN: _____

FOR BILLING PURPOSES WE REQUIRE THIS FORM TO BE FULLY COMPLETED. WE RESERVE THE RIGHT TO RESCHEDULE ANY APPOINTMENTS DUE TO INCOMPLETE FORMS OR TARDINESS. THANK YOU FOR YOUR COOPERATION. IF ANY INFORMATION CHANGES A NEW FORM MUST BE COMPLETED.

INFORMATION VERIFIED (DATE / INITIALS)
