Gastroenterology Consultants of Long Island, PC
Accredited Endoscopy Services OBS, PC

Ian M. Storch, D.O.

Patient Registration

Patient Name _____ S S # _____

Street Address _____ Birthdate _____

City _____ State _____ Zip _____ Gender M F

Home Phone _____ Work _____ Cell _____

Email _____

Emergency Contact _____ Phone # _____ Relation _____

Referring Doctor _____ Tel # _____

Pharm _____ City _____ State _____ Zip _____

Insured Name _____ Birthdate _____ Tel # _____

Street Address _____ City _____ State _____ Zip _____

Social Security # _____ Relationship to Patient _____

Primary Insurance Name _____

ID # _____ Telephone # _____

Secondary Insurance Name _____

ID # _____ Telephone # _____

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

If you are enrolled in an HMO insurance plan that requires authorization from your primary care physician (Referral Form) **you must present the referral form at the time of visit**. If you have **no** referral form **you will be responsible for all disallowed charges by your insurance plan. I understand that my insurance carrier may deny payment for tests/services deemed necessary by my Physician and accept that I would be fully responsible for the entire bill in such a circumstance.**

Medicare B Patients

"I request that payment of authorized Medicare benefits be made to Gastroenterology Consultants of Long Island, PC for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services."

A copy of following information has been made available to me: Notice of Privacy Practices, information regarding the ownership of the practice; the expertise of the associated physicians, the Patient Bill of Rights and Responsibilities; the Patient Grievance Process; DNR policy.

PATIENTS (Or Authorized) SIGNATURE: _____ DATE: _____