Statesboro Internal Medicine
The Office of Mark P. Crick, MD
1497 Fair Road, Suite 205 Statesboro, GA 30458
Phone: (912)486-1480 Fax: (912) 486-1489

PATIENT REGISTRATION

Last Name _____First Name _____MI _____

SSN _____ Sex ____ Date of Birth _____Marital Status _____

Mailing Address _____ Apt # _____

City _____ State _____ Zip _____

Home # _____ Work # _____ Cell # _____

Preferred Contact #_____

E-mail _____

PHARMACY_____

If patient is a minor or dependent, please complete the following information:

Responsible Party _____ Relationship to Patient _____

Home # _____Work # _____Cell # _____

PRIMARY INSURANCE (A copy of your insurance card is required)

Insurance _____ ID _____ Group _____

Insured's Name _____ Insured's Date of Birth _____

Social Security Number _____ Relation to Patient _____

Employer _____

SECONDARY INSURANCE (A copy of your insurance card is required)

Insurance _____ ID _____Group_____

Insured's Name _____ Insured's Date of Birth _____

Social Security Number _____ Relation to Patient _____

EMERGENCY CONTACT

Name _____ Relation to Patient _____

Home # _____ Work # _____ Cell # _____

CONSENT FOR TREATMENT

The signature below serves as consent for services/treatment/referrals to be rendered by East Georgia Gastroenterology for the above named patient. This also authorizes the practice to release or receive protected health information for the purpose of treatment, payment, or health care operations necessary for such services.

_____ _____
Patient (or legal guardian) signature **Date**

_____ _____
If legal guardian, print name **Relation to Patient**