



SAN JOSE GASTROENTEROLOGY
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PATIENT REGISTRATION FORM

Date of Registration: _____ Referring Physician: _____

DEMOGRAPHIC

Patient's Name: _____ **Social Security No:** - -
Birthdate _____ **Gender:** Male Female
Home Address: _____ **Apt#:** _____
City: _____ **State:** _____ **Zip:** _____
Home Phone : _____ **Cell Phone:** _____ **Work Phone:** _____
Email Address: _____
Preferred Contact (please check one): Home Phone Cell Phone Work Phone Email
Ethnicity: African-American Caucasian Chinese Filipino Hispanic Korean Portuguese Vietnamese Other:
Languages: English Chinese French Korean Portuguese Spanish Tagalog Vietnamese Other:

EMPLOYER INFORMATION

Name: _____ **Phone #:** _____
Address: _____
Insurance Plan Name: _____

FAMILY INFORMATION

Name of Spouse: _____
Contact Person In Case Of Emergency _____ **Phone #:** _____
Referred by (Name & Address): _____
Has any member of your immediate family has been treated by this office? Name if yes: _____

I hereby authorize the medical staff to be my attending physicians and to administer to me any examination treatment, and medications he or she deems therapeutic to my complaints. I hereby authorize the release of any information to insurance carriers to process my medical claims and I irrevocably assign to the doctors at San Jose Gastroenterology, MC all payments for medical services rendered. I understand that I am responsible for payments for services not covered by my insurance company.

Signature of Patient (or responsible party-please mark relation to patient) _____ Date _____

Please choose ONE of the following choices below

I hereby authorize San Jose Gastroenterology, MC, its clinical staff and clerical staff, to discuss my medical information to any member of my family for the purposes of my medical care. (Patient's signature)

OR

I hereby authorize San Jose Gastroenterology, MC, its clinical staff and clerical staff, to discuss my medical information ONLY to _____, my _____ (relationship). (Patient's signature)

OR

I **do not** wish San Jose Gastroenterology, MC to discuss my medical information to anyone, except as permitted by privacy laws for the purposes of my medical care and insurance payments of my medical claims. (Patient's signature)