ERICK H. ALAYO, M.D.
DIPLOMATE IN INTERNAL MEDICINE AND GASTROENTEROLOGY
GASTROINTESTINAL AND LIVER DISEASE • DIAGNOSTIC AND THERAPEUTIC ENDOSCOPY
www.gastrosb.com

PATIENT INFORMATION

Last Name: First Name: MI:

Birth Date: ☐ Male ☐ Female SSN:

Address:

City:

State: Zip Code:

Email:

Can we email you appointment information? ☐ Yes ☐ No

Race:
☐ White/Caucasian ☐ Black or African American
☐ American Indian or Alaska Native ☐ Asian
☐ Native Hawaiian or Other Pacific Islander ☐ Declined

Ethnic: ☐ Hispano or Latino ☐ Not Hispanic or Latino

Preferred Language: ☐ Spanish ☐ English

Home Phone: Employer:

Cell Phone: Work Phone:

Emergency Contact:
Name Relationship Phone Number

Referring Dr.: Primary Dr.:
Last Name First Name Last Name First Name

INSURANCE INFORMATION

Primary Insurance: Secondary Insurance:

Insured Person: Insured Person:

Date of Birth: SSN: Date of Birth: SSN:

Tricare Patientss, please enter Sponsor's Social Security

INSURANCE AUTHORIZATION

I hereby authorize Erick H. Alayo Medical Corporation to treat the patient listed above. I hereby authorize payment directly to the above name physicians of the amount due in all pending claims for medical expenses payable under the terms of my insurance. I agree that any balance not covered by my insurance will be paid by me if the insurance determines it is my responsibility. I aurthorize any physician, hospital or clinic to provide full detail of me or my dependent medical history and treatment to the above named physicians. In addition, I authorize the physician's lited above to release any information necessary to assist in medical treatment and /or insurance payment.

SIGNATURE: DATE:

Relationship to patient (if patient did not sign) ☐ Papers received

Diagnostic and Therapeutic ERCP Endoscopic Ultrasound Hemorrhoid Banding
Barrett's Ablation Upper and Lower Endoscopies Hydrogen Breath Test