PENINSULA
GASTROINTESTINAL
SPECIALISTS, INC

EDWARD K. ONUMA, M.D., Ph.D.
EUGENE Y. LEE, M.D.

100 S. Ellsworth Ave, Ste. 507
San Mateo, CA 94401
T 650 342-7432
F 650 342-3239
www.mygidoctors.com

Date:________________ Primary care physician: ________________________

Patient's Name:____
(last) *(first)* *(middle)*

Address: ____
City *State* *Zip Code*

Billing Address *(if different from above)*:____

Phone #'s
Home: ☐_____________________Cell: ☐_____________________email:_______________________
(check preferred number)

Marital Status: _________ Birthdate: *(MM/DD/YY)*_____________________ Sex: ☐ M / ☐ F

Ethnicity: ☐ Hispanic or Latino / ☐ Not Hispanic or Latino

Race *(check one box that best describes you)*: ☐ Asian ☐ Black/African American ☐ Hispanic or Latino ☐ Native American ☐ Native Hawaiian or Other Pacific Islander ☐ White/Caucasian ☐ Multiracial ☐ Other ____________ ☐ Unknown/Not Reported ☐ I prefer not to answer

Preferred Spoken Language *(if other than English)*: _______________________ ☐ I prefer not to answer

S.S.#: ___________________ *(optional, unless needed for insurance billing purposes please complete)*

Employer:_________________________________ Work #:_____________________

Spouse/Domestic Partner: ____________________________ Phone #___________________

Emergency Contact *(if different from above)*: ________________________ Phone #_______________

Primary Insurance:_______________________________________
(we would like photocopy of all your insurance cards)

Other Insurance: ____

I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE PHYSICIAN AND I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL NON-COVERED CHARGES. PAYMENT IS DUE AND PAYABLE AT THE TIME SERVICES ARE RENDERED. I UNDERSTAND THAT MY CREDIT CARD IS ON FILE AND THAT ANY REMAINING BALANCE I OWE MAY BE CHARGED TO MY CREDIT CARD. I ALSO AUTHORIZE MY PHYSICIAN TO RELEASE ANY INFORMATION TO MY INSURANCE COMPANY FOR THE PROCESSING OF MY INSURANCE CLAIMS. HMO PATIENTS WHO DO NOT HAVE PRIOR AUTHORIZATION TO SEE DR. ONUMA OR DR. LEE WILL BE FINANCIALLY RESPONSIBLE FOR ANY CHARGES INCURRED.

Insured's Signature: _________________________________ **Date:** __________________