Treasure Valley Gastroenterology Specialists
Raquel Croitoru, M.D.
Board Certified Gastroenterology
Fellow American College of Gastroenterology

PATIENT INFORMATION

Date Completed: ____________________________

Name: ____________________

Date of Birth: ____________ **Age:** ______ **Sex:** ______ **Marital Status:** ____________

Address: ____________________

City: ____________ **State:** ____________ **Zip:** ____________

Home Phone: ____________ **Cell Phone:** ____________

SS#: ____________ **Email Address:** ____________

Employer: ____________ **Occupation:** ____________

Address: ____________ **Phone:** ____________

Primary Insurance: ____________________

Secondary Insurance: ____________________

Other Insurance: ____________________

Spouse or Responsible Party: ____________________

Date of Birth: ____________ **SS#:** ____________ **Employer:** ____________

Work Phone: ____________ **Cell Phone:** ____________

In Emergency Please Notify: ____________________

Address: ____________ **Phone:** ____________

Work Phone: ____________ **Cell Phone:** ____________

Referring Doctor: ____________________

Primary Care Doctor: ____________________

Preferred Pharmacy/Location: ____________________

AS A COURTESY we will bill your primary and secondary insurance carrier if you provide **ALL** necessary information (such as insurance cards and/or completed and signed claim forms if your carrier requires it and their **CORRECT** billing address). Co-pays and share of cost are collected for each visit. **A $35.00 FEE WILL BE CHARGED FOR ALL RETURNED CHECKS.**

SIGNATURE OF PATIENT OR GUARDIAN: ____________________

FOR BILLING PURPOSES WE REQUIRE THIS FORM TO BE FULLY COMPLETED. WE RESERVE THE RIGHT TO RESCHEDULE ANY APPOINTMENTS DUE TO INCOMPLETE FORMS OR TARDINESS. THANK YOU FOR YOUR COOPERATION. IF ANY INFORMATION CHANGES A NEW FORM MUST BE COMPLETED.

222 W. Iowa Ave. Ste A ● Nampa, ID 83686 Phone: 208-467-3432 Fax: 208-467-4147