Gastroenterology Associates of Western Michigan PLC
2093 Health Dr., Suite 201
Wyoming, MI 49519
(616) 452-7099
(616) 452-4142 Fax

Allan Coates, D.O.
David Tabor, D.O.

Date _____

Name _____ **Date of Birth** _____

Former Name(s) _____

Address _____ **Apt. No.** _____

City/State _____ **Zip Code** _____

Phone Information: Home ( ) _____ Cell ( ) _____ Work ( ) _____

Email Address _____

Social Security No. ____ ___ _____ Male _____ Female _____

Preferred Language: English ___ Spanish ___ Other ____

Race: American Indian or Alaska Native ___ Asian ___ Black or African American ___
Native Hawaiian or Other Pacific Islander ___ White ___ Other Race ___ Unknown ___ Refuse ___

Ethnicity: Hispanic or Latino ___ Non-Hispanic or Latino ___ Unknown ___ Refuse ___

Marital Status: Single ____ Married ____ Widowed ____ Divorced ____

Emergency Contact _____ Relationship _____

Phones – Home ( ) _____ Cell ( ) _____ Work ( ) _____

Primary Care Physician _____

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Insurance Company _____

Contract No. _____ Group No. _____

Card Holder Name _____ Date of Birth _____

2nd Second Insurance Company _____

Contract No. _____ Group No. _____

Card Holder Name _____ Date of Birth _____

By signing this document I authorize payment directly to Gastroenterology Associates of Western Michigan PLC for medical services. I understand that I will be responsible for any balance not covered by my insurance company. I authorize the release of all information regarding my medical condition as necessary to process any insurance claims. I permit a copy of this to be used in place of the original. I also understand that by supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third- party automated outreach & messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, missed appointment, overdue wellness visit, or any other reasonable healthcare related communication. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information regarding healthcare events, unpaid balances, missed appointments, and to leave a reminder message on my voice mail or answering system if I am unavailable at the number provided by me.

X Signature _____ ***Date*** _____