Hudson Center for Digestive Health
Dr. Kovil Ramasamy MD, FACG, FACP
534 Avenue E, Suite 1-A, Bayonne, NJ 07002
Ph (201) 858-8444
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First Name: ________________________ MI: ____ Last Name: ___________________________

Address: ____________________________ City: ________________ State: ____ Zip: ________

Home Phone: _______________ Cell Phone: _______________ Cell Phone: _______________

Date of Birth: ________________ Sex: M ___ F ___ U ___

Marital Status: S __ M __ D __ W __ Email Address: __________________________________

Race: ___________________________ Ethnicity: _______________________________________

Primary Language: ________________________ Translator Required? Y ___ N ____

Primary Doctor: ____________________________ Doctor's Phone: ________________________

Referred by: _______________________________ Referring Doctor: ______________________

Emergency Contact: _________________________ Phone: ________________ Rel: __________

Your local pharmacy: _____________________ Phone: __________________________________

Address: ____________________________ City: ________________ State: ____ Zip: ________

Mail Order Pharmacy: __________________________ Phone: ____________________________

Primary insurance: _____________________________ ID#: ______________________________

Insured Name: _________________________ DOB: _____________ Relationship: ___________

Secondary insurance: _____________________________ ID#: ____________________________

Insured Name: _________________________ DOB: _____________ Relationship: ___________

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Hudson Center for Digestive Health or insurance company to release any information required to process my claim.
I also authorize medical staff to discuss my medical history, diagnosis, treatment and prognosis with other medical providers and organizations that participate in my care.

Patient/Guardian signature: ____________________________________ Date: _____________