Digestive Disease Specialist,P.C.

PATIENT INFORMATION

Please print

Patient Name:_____ _____ _____ _____
Last First MI Preferred Name

□ Male □ Female Patient Date of Birth:_____ Social Security:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____
Marital Status: ( ) Married ( ) Single ( ) Divorced ( ) Widowed

Pharmacy:_____ Pharmacy Location:_____

Email address: _____

Race:_____ Ethnicity:_____ Language:_____

Do you need an interpreter? Yes or No ____Spanish Other_____
Family Dr.:_____ Referring Dr.:_____

EMPLOYER INFORMATION

Employer Name: _____

Address:_____

Occupation:_____

EMERGENCY CONTACT

Name:_____ Relationship:_____

Home Phone:_____ Work/Cell Phone:_____

May we disclose medical information? (Circle one) Yes or No

INSURED PARTY

Name:_____ Phone:_____

Social Security: _____ Date of Birth:_____

Relationship to Patient:_____ Place of Employment:_____

I authorize direct payment of medical benefits and/or private insurance benefits on my behalf for any services furnished to me by **Digestive Disease Specialists, P.C.** be submitted directly to their office. I authorize the release of any medical information necessary to coordinate care with other physicians and to process claims. I understand that I am financially responsible for all charges whether or not paid by your insurance company. Therefore, it is necessary for our patients to be responsible for checking with their insurance company for specific requirements of their plan.

SIGNATURE_____DATE_____

R- 01/2014, 12/2014, 3/2016, 6/2018,1/2019, 4/2019