PATIENT INFORMATION

Please print

Patient Name_____

Last First MI Preferred Name

Address_____

City_____State_____Zip Code_____

Home Phone_____Work Phone_____Cell Phone_____

Patient Date of Birth_____Social Security_____

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_____Work Number_____

Address_____

Occupation_____

EMERGENCY CONTACT

Name_____Relationship_____

Home Phone_____Work/Cell Phone_____

Disclose Medical Information (Check) _____Yes or _____No

INSURED PARTY

Name_____Phone_____

Social Security _____Date of Birth_____

Relationship to Patient_____

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_____