



PATIENT INFORMATION FORM

Last Name: _____ First Name: _____ Middle: _____

Preferred Name: _____

Pharmacy & Location: _____

Referred by: _____ Primary Care Physician _____

Reason for Today's Visit: _____

Date of Birth: ___/___/___ Sex: M or F SS#: ____-____-____

Race: American Indian/Alaska Native Black/African American White/Caucasian Asian
 Hawaiian/Pacific Islander Other Unknown Declined

Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown Declined

Preferred Language: _____ Marital Status: (circle) S M D W

Local Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____

Alternate Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Email Address: _____

*After providing a phone number and an email address to contact you for our Patient Portal, please place a ✓ beside the best way to contact you.

Employer's Name: _____

I authorize FDHS to contact PATIENT at the following email address: _____

Persons to whom we may release information (Please select what type of information we may discuss with them by initialing the applicable blank(s)):

I authorize FDHS to share Patient **medical** _____ **billing** _____ information with the following individual:

Name _____ Relationship to patient _____

I authorize FDHS to share Patient **medical** _____ **billing** _____ information with the following individual:

Name _____ Relationship to patient _____

EMERGENCY CONTACT: _____ Phone #: _____ Relationship: _____

INSURANCE INFORMATION

Responsible Party (if different than patient)

Last Name: _____ First Name: _____ Middle Initial: _____

Local Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____

Date of Birth: ____/____/____ Phone: _____ Email: _____

Primary Insurance

Policy Holder's Name: _____ DOB: ____/____/____ Relationship to Patient: _____

Plan Name: _____ Group Name: _____ Group #: _____ ID #: _____

Coverage Type: Self Family Dependent Handicapped dependent Sponsored dependent Injured Plaintiff
 Student Part-time Student Full-time student

Secondary Insurance

Policy Holder's Name: _____ DOB: ____/____/____ Relationship to Patient: _____

Plan Name: _____ Group Name: _____ Group #: _____ ID #: _____

Assignment and Authorization of Benefits: I authorize the release of any medical information necessary to process my claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing. I hereby authorize Florida Digestive Health Specialists to apply for benefits on my behalf for covered services rendered by him/her or by his/her order. I request that payment from my insurance company be made directly to Florida Digestive Health Specialists (or the party who accepts assignment). I certify that the information I have reported with regard to my insurance coverage is correct. I understand that my insurance carrier may pay less than the actual bill for services rendered. I agree to be responsible for the payment of all services rendered on my behalf or my dependents. I agree to pay any reasonable collection fees, including reasonable attorney fees necessary to collect my debt.

Patient or Responsible Party Signature: _____ Date: _____