Florida Digestive Health Specialists

MR#_____

# 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: _____City: _____

State: _____ Zip: _____ If seasonal address, list dates:_____

□ 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 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:

PRINT Name_____ Relationship to patient_____

I authorize FDHS to share Patient M**edical** _____B**illing**_____ information with the following individual:

PRINT 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 #: _____

Member 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 #: _____

Member 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 my insurance company or me 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 concerning 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 provided 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: _____