PATIENT REGISTRATION/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: ____

City: ____ State: _______ Zip: ________________

Alternate Address: ____

If seasonal address, list dates:________________________________

□ Home Phone #: _________________________ □ Work Phone #: _______________________

□ Cell Phone #: _________________________ Email Address: ____

Employer's Name: ____

I authorize FDHS to contact PATIENT at email address □ Yes □ No

Persons to whom we may release information:

I authorize FDHS to share Patient Medical _______Billing______ 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: ____________________________

Relationship to Patient _________________

Primary Insurance

Policy Holder's Name: ________________________________ DOB: ____/____/____

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: __________________