DIGESTIVE HEALTH SPECIALISTS OF THE SOUTHEAST
PATIENT INFORMATION

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

Address:_____Apt#:_____City:_____State:_____Zip:_____

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

Age:_____ Sex: M F Date of Birth:_____ Marital Status:_____SS#:_____

Employer's Name:_____

Address: _____ City:_____ Zip:_____

Spouse Name:_____Home#_____Work#_____

Emergency Contact:_____Relationship:_____Phone#:_____

INSURANCE INFORMATION OF POLICY HOLDER

Primary Insurance:_____Address:_____State/Zip:_____Phone#:_____

ID#:_____ Group#:_____ Policy Holder Employer:_____

Policy Holder: _____Date of Birth:_____ SS#: _____ Relationship:_____

Secondary Insurance:_____Address:_____State/Zip:_____Phone#:_____

ID#:_____ Group#:_____ Policy Holder Employer:_____

Policy Holder: _____Date of Birth:_____ SS#: _____ Relationship:_____

Patient Consent to Share Personal Health Information

I hereby authorize Digestive Health to share my personal health information with named persons below until further written notice from me:

Name:_____Relationship to Patient::_____Phone Number: _____

Name:_____Relationship to Patient::_____Phone Number: _____

Assignment and Authorization of Benefits

I hereby give authorization for payment of insurance benefits to be made directly to Digestive Health for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney fees. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this Agreement is as valid as the original.

Acknowledgement of Review of Notice of Privacy Practices

I have been given the opportunity to review this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature: _____ Date: _____ Witness: _____ Date: _____