DIGESTIVE HEALTH SPECIALISTS

PATIENT INFORMATION

Name: _____Date of Birth: _____/_____/_____
First MI Last

Address: _____
Street City State Zip

Mailing Address: _____

Please Select One: _____Male _____Female Social Security Number _____-_____-_____

Telephone #: _____ May we leave a message on this number ____Yes ____No

Cell# _____May we leave a message on this number ____Yes ____No

Patient E-Mail: _____

Employer: _____Work #: _____

Emergency Contact: _____ Phone # _____Relationship: _____

Name of Primary Care Physician: _____ Phone #: _____

Address: _____

INSURANCE INFORMATION

Primary Insurance: _____ Policy # _____ Group # _____

Address: _____ Phone # _____

Policyholder: _____ DOB _____/_____/_____SS# _____/_____/_____

Secondary Insurance: _____Policy # _____ Group # _____

Address: _____ Phone #: _____

Policyholder: _____ DOB _____/_____/_____SS# _____/_____/_____

PATIENT CONSENT TO SHARE PERSONAL HEALTH INFORMATION

Name: _____ Relationship to patient: _____ Phone# _____

Name: _____ Relationship to patient: _____ Phone# _____

☐ Decline all request to share personal health info

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 may medical information will used and disclosed. I understand that I am intitled to receive a copy of this document.

_____ _____ _____ _____

Signature Date Witness Date