PATIENT REGISTRATION FORM

Date_____/_____/_____ Patient Number_____

PATIENT INFORMATION (Required data)

Please provide your Driver's License to the Receptionist to scan.

What is the name of the Digestive CARE Provider you are seeing?_____

Social Security #_____ - _____ - _____

Gender □ Male □ Female Date of Birth____/____/_____

First Name _____

Middle _____

Last Name_____Suffix_____

□ Single □ Married □ Divorced
□ Separated □ Widowed □ Domestic Partner

□ Black □ Caucasian □ Hispanic
□ Asian □ American Indian □ Pacific Islander
□ Asian Pacific Amer. □ Native Alaskan □ Other Race

Patient Primary Language _____

□ Employed □ Unemployed □ Retired □ Student

Employer _____

Employer Address _____

_____

City_____

State/Zip _____

Employer Phone (_____)_____

Address (Bill to) _____

Apt. _____

City_____

State/Zip _____

Secondary Address _____

Apt. _____

City _____

State/Zip _____

E-mail_____

□H □W □C Primary Phone (_____)_____

□H □W □C Secondary Phone (_____)_____

Consent to leave phone message. □ Yes □ No

Preferred method of contact for appointment reminders:

□ E-mail □ Call □ Text

How did You Hear About Us?

□ Event □ Internet □ Referring Provider
□ Friend □ Magazine/Newspaper □ Television
□ Family □ Office Staff □ Yellow Pages
□ Hospital/ER □ Radio □ Other
□ Insurance Company □ Research Patient _____

REFERRING PHYSICIAN

Referring Physician_____ Phone (_____) _____

Primary Care Physician_____Phone (_____)_____

PHARMACY INFORMATION

Pharmacy Name_____Pharmacy Phone (_____) _____

Pharmacy Address_____ City_____ State/Zip _____

I give consent to import my medication history from a trusted and secure external source. _____Patient Initials

PATIENT REPRESENTATIVE

Relationship to Patient _____Phone (_____) _____

First Name _____ Last Name _____

I authorize Digestive CARE to discuss with the above-named contact the following issues related to my care:

□ All PHI (Protected Healthcare Information) □ Emergency Contact Only □ Medical Only □ Financial Only _____Patient Initials

I have an *Advanced Directive* or *Health Care Directive*. □ Yes □ No

INSURANCE INFORMATION (Required Data)

Please provide your Insurance card to the Receptionist to scan.

Please indicate your Plan type: □ Individual/Exchange □ Employer/Group □ Employer Sponsored Medicare
□ Medicare □ Medicare Advantage □ Medicare Supplement □ Medicaid Managed

Insurance Company _____Policy # _____ Group #_____

Plan Name _____ State Issued:_____

Insured (if other than Patient) _____ Relationship _____

Insured's Date of Birth _____ /_____ /_____ Phone (_____) _____

Insured's Employer _____ City/State _____Employer Phone (_____)_____

Please indicate your Plan type: □ Individual/Exchange □ Employer/Group □ Employer Sponsored Medicare
□ Medicare □ Medicare Advantage □ Medicare Supplement □ Medicaid Managed

2nd Insurance Company _____Policy # _____ Group #_____

Plan Name _____ State Issued:_____

Insured (if other than Patient) _____ Relationship _____

Insured's Date of Birth _____ /_____ /_____ Phone (_____) _____

Insured's Employer _____ City/State _____Employer Phone (_____)_____

ACKNOWLEDGEMENT OF PRIVACY NOTICE

Your initials indicate that you were given and have read, understand and acknowledge *Digestive CARE's* "Notice of Privacy Practices", which describes how we use and disclose your health information.

_____Patient Initials Date____/_____/_____

CONSENT FOR MEDICAL TREATMENT

I, the undersigned, the patient (or the patient's duly authorized representative) do hereby voluntarily consent to and authorize medical care encompassing all diagnostic and therapeutic treatments considered necessary or advisable in the judgment of the physician, his assistants or designees. I am aware that the practice of medicine and surgery is not an exact science and acknowledge that no guarantees have been made to me as to the results of treatment or examinations performed. I understand if I am not compliant with any recommendations made by my physician this could compromise my care. All the above will be discussed with me, by the attending provider prior to any proposed testing or any type of surgical procedures to be scheduled.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND PAY BENEFITS TO PHYSICIAN

1. I hereby authorize *Digestive CARE* to release or receive any information necessary to expedite insurance claims.
2. I hereby authorize *Digestive CARE* to bill my insurance company directly for their services.
3. I hereby authorize payment directly to the Physician of any insurance benefits otherwise payable to me.
4. In the event I receive payment from my insurance carrier, I agree to endorse any payment I receive over to the Physician for which these fees are payable.

I certify that I understand and accept the contents for this form.

SIGNATURE (Patient or Authorized Representative) _____ Date____/_____/_____

PRINTED NAME (Authorized Representative) _____