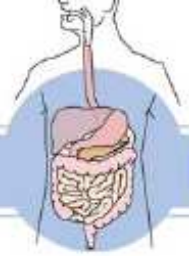

Digestive and Liver Center of Florida, P.A.

Patient Information Form

Last Name	First Name	Middle/Maiden Name	Date of Birth	Sex
				☐ Male ☐ Female

Mailing Address	Apt./Lot	City	State/Zip	Social Security #

Marital Status	Mother's Name if Minor Patient	Father's Name if Minor Patient
☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated		

Home Phone	Work Phone	Mobile Phone	Email	Driver's License Number / State
( )	( )	( )		

Employer/Company Name	Employer Mailing Address	City	State/Zip	Occupation

Spouse/Parent Name	Spouse/Parent SSN	Spouse/Parent Employer	Employer Address	Employer Phone #

Emergency Contact if different than parent or spouse listed above.	Emergency Contact Address	City	State/Zip	Relationship to Patient

Emergency Contact Phone Numbers	Home ( )	Work ( )	Other ( )

Insurance Information

Primary Carrier Insurance Company	Effective Dat	Secondary Carrier Insurance Company	Effective Date

Insurance Carrier Mailing Address	City	State/Zip	Insurance Carrier Mailing Address	City	State/Zip

Policy Holder's Name	Employer of Policy Holder	Policy Holder's Name	Employer of Policy Holder

Policy # / Social Security #	Group #	Policy # / Social Security #	Group #

Responsible Party Information

If other than parent/spouse listed abo ve

Head of Household or Parent with Custody of Minor	Relationship to Patient	Responsible Party's Social Security #

Mailing Address	Apt./Lot	City	State/Zip	Phone# Home ( ) Work ( ) Mobile ( )

Responsible Party's Employer	Apt./Lot	City	State/Zip	Employer's Phone #
				( )

Authorization for Treatment

I authorize Digestive and Liver Center to perform procedures and treatment including the administration of medicine and local anesthetics along with other surgical and medical procedures that may be necessary. I authorize the release of any medical information necessary to process a claim and hereby assign benefits pa yable to Digestive and Liver Center in the event of another health insurance becoming primary over my health insurance. To further provide continuity of care, I authorize the release of medical information to specialty physicians under contract with Digestive and Liver Center. Furthermore, any services not covered by my insurance will become my responsibility for full payment of services rendered by Digestive and Liver Center.

Patient/Legal Guardian Signature _____ Date _____

Patient/Legal Guardian (pr int) _____

710-0218 REVISED 06/06

White - Medical Record Yellow - Accounting

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