Florida Digestive Health Specialists

Thank you for choosing FDHS. We would like to invite you to join our Patient Portal. Request an invite on our website or ask the receptionist to invite you.

**Don't forget to "Like Us" on Facebook.

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PATIENT REGISTRATION FORM

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

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: () Not Hispanic or Latino () Hispanic or Latino () Declined () Unknown

Primary Language: _____ Marital Status: (circle) S M D W

Local Address: _____ Apt # :_____ City : _____ State: _____ Zip: _____

Alternate Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #:_____ Fax#: _____

Email Address: _____

Employer's Name: _____Occupation: _____

EMERGENCY CONTACT: _____ Phone #: _____ Relationship: _____

INSURANCE INFORMATION

Primary Insurance

Policy Holders Name: _____ DOB: ____/____/____ Relationship to Patient: _____

Plan Name: _____ Group Name: _____ Group #: _____ ID # : _____

Address: _____State: _____ Zip: _____ Phone #:_____

Secondary Insurance

Policy Holders Name: _____ DOB: ____/____/____ Relationship to Patient: _____

Plan Name: _____ Group Name: _____ Group #: _____ ID # : _____

Address: _____State: _____ Zip: _____ Phone #:_____

PRIMARY CARE DOCTOR: _____Phone #: _____

Who Referred You? _____ Phone#: _____

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 me or my insurance company 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 with regard to 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 rendered on my behalf or my dependents. I agree to pay any collection fees, including attorney fees if necessary to collect my debt.

Patient or Responsible Party Signature: _____ Date: _____