PATIENT REGISTRATION

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent. Please fill in the blanks below the line.

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Sr. ☐ Jr. ☐ Other_____

Patient Name	Sex	Age	Marital Status
Patient's Social Security Number	Date of Birth	Employer/ Occupation	
Home Address	City	State	Zip
Mailing Address if Different	City	State	Zip
Home Phone Number:	Work Phone Number:	Cell Phone Number:	
Emergency Contact Name:	Contact Phone Number:		
Your E-Mail Address:			
Referred by, Please circle one: Consult a Nurse Health grades JFK E.R. PW E.R. PCP Other:_____			
Pharmacy:		Phone Number:	
Primary Care Doctor:		Phone Number:	
Other Doctor/Specialist:		Phone Number:	

FINANCIAL INFORMATION: PERSON RESPONSIBLE FOR FEES

Primary Insurance Company		Claim Address
Name of Policy Holder if Different from patient	DOB	Social Security Number
Secondary Insurance Company		Claim Address
Name of Policy Holder if Different from patient	DOB	Social Security Number

I authorize Digestive Disease Center of the Palm Beaches to release my records, give any medical or financial information out to the following people:

1. _____ Relationship to you: _____
2. _____ Relationship to you: _____
3. _____ Relationship to you: _____
4. _____ Relationship to you: _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

_____ _____

Patient or Authorized Representative Date