CENTER FOR DIGESTIVE HEALTH & PAIN MANAGEMENT PATIENT REGISTRATION Revised 11/14vd

Last Name_____ First_____ MI_____

Local Address _____City_____ State____ Zip_____

Phone: Home _____ Work _____ Cell _____

SS#_____ Date of Birth_____ Age_____ Sex: M / F

Please circle: **Marital Status**: S M W D **Race:** Asian Black White White-Hispanic Black-Hispanic American Indian Alaskan Eskimo Other (Verification of Race is a reporting requirement of the State of Florida)

Employed by _____Occupation_____

Spouse's Name_____ SS#:_____ DOB:_____

If not a full time resident, circle months you are in Florida: Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

Northern Address_____
Phone_____

RESPONSIBLE PARTY (If other than patient) Name:_____

Address_____

Relationship to Patient_____ Phone: Home_____ Work _____Cell _____

EMERGENCY CONTACT PERSON (If other than spouse) Name:_____

Address_____

Relationship to Patient_____ Phone: Home_____ Work _____Cell _____

Who is your local family physician?_____

Release of Medical Records:
I authorize the Center to release all or part of my medical records when required for submission of any insurance claim for payment, or to my employer (if a worker's compensation claim). I authorize reports of my evaluation, procedures and any follow-up evaluations to be sent to or discussed with my physicians and health care entities responsible for my continuing care.

Please list below the names, relationships and phone numbers of 2 people with whom we may share your protected health care information. You may change or cancel these named people by giving us written notice.

Name: _____ Relationship:_____ Phone:_____

Name: _____ Relationship:_____ Phone:_____

Date: _____**Patient Signature:** _____**Witness:** _____
Medical Record # _____