

CENTER FOR DIGESTIVE HEALTH & PAIN MANAGEMENT PATIENT REGISTRATION Revised 11/14/04

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 # _____