CENTER FOR DIGESTIVE HEALTH & PAIN MANAGEMENT PATIENT REGISTRATION Revised 07/15 cg

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/African American Caucasian Chinese Filipino Japanese Native Hawaiian Multi Racial Pacific Islander American Indian Alaskan Native Other

(Verification of Race is a reporting requirement of the State of Florida)

Employed by ____Occupation___________________________

Spouse's Name_______________________________ SS#:________________________ DOB:_____________

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 ______________

Your local family physician: ______________________ Physician who referred you for procedure: _______________

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 # ______________________