Florida Gastro Partners, LLC

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Name (Last) _____ (First) _____ M.I. _____ Date _____

Local Address _____ _____ M ☐ F ☐

City _____ State _____ Zip _____

Permanent Address _____

City _____ State _____ Zip _____

Home Phone _____ _____ Cell Phone _____

Date of Birth _____ SS # _____

Marital Status _____ Spouse's Name _____

Employer _____ Occupation _____

Address _____ City _____ State _____ Zip _____

Employer Phone # _____

Name of Nearest Relative Not Living With You _____

Address _____ City _____ State _____ Zip _____

Emergency Phone # _____

Primary Insurance _____ ID # _____ Group # _____ Phone # _____

Secondary Insurance _____ ID # _____ Group # _____ Phone # _____

How were you referred to SFGA? _____

Primary Care Physician _____

Allergies to Medication _____

_____

Languages Spoken _____ Do you have a Living Will ☐ Yes ☐ No

I hereby authorize SFGA to perform treatment that the Doctor deems necessary and the Doctor and I agree upon.

YOUR SIGNATURE IS NECESSARY FOR US TO PROCESS ANY INSURANCE CLAIMS AND TO INSURE PAYMENT OF SERVICES RENDERED

__The Non-Medicare Patient:__ I authorize the release of all medical information necessary to process this claim and that is pertinent to my medicare care. I assign all medical and/or surgical benefits, including major medical benefits to which I am entitled to Physician/Clinic. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. The Medicare Patient/Lifetime Authorization: I request that payment of authorized Medicare benefits be made to me or on my behalf to Physician/Clinic for any services furnished me by that provider. I authorize any holder of medicare information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

Signature _____ Date _____