



PATIENT INFORMATION FORM

				DATE	
PATIENT NAME - FIRST		MIDDLE		LAST	
				SEX <input type="checkbox"/> M <input type="checkbox"/> F	
PERMANENT ADDRESS				CITY	
				STATE	
				ZIP	
HOME PHONE		WORK PHONE		BIRTHDATE	
SOCIAL SECURITY #		DRIVER LICENSE #		EMPLOYER	
GUARDIAN (Relationship)			GUARDIAN SOCIAL SECURITY #		GUARDIAN EMPLOYER
SPOUSE			SPOUSE SOCIAL SECURITY #		SPOUSE BIRTHDATE
EMERGENCY CONTACT			PHONE NUMBER		
REFERRING PHYSICIAN OR FAMILY DOCTOR					

AUTHORIZATION TO RELEASE INFORMATION

I, _____ authorize Digestive Health Associates of Northern Michigan, P.C. (Drs. Antinozzi, Barnes, Galan, Hegewald, Sanford, Sue Coffin, P.A.-C and Krystal Auernhamer, P.A.-C) to release and/or discuss information relevant to my care to the following individuals:

_____ Spouse (Name) _____

_____ Other (Name and relationship) _____

I also authorize information about my health care, including appointments, test results or other messages, to be left on my answering machine, in the event that I am not available.

_____ YES _____ NO

I request payment of authorized Medicare or other insurance benefits be made to either myself or on my behalf to Digestive Health Associates of Northern Michigan for any services rendered to me. I authorize release of medical information about me to the Health Care Financing Administration (Medicare) and/or my insurance carrier. This information is to be used for the purpose of evaluating and administering benefits.

Medicare _____

Other Insurance (name of company) _____

I understand that I am financially responsible for any amount not covered by my insurance contract. I accept responsibility for obtaining necessary referral forms.

This release will be considered valid from the date indicated below and will remain in effect until such time as I withdraw it in writing.

Signature of patient

Date

Witness