



## PATIENT INFORMATION FORM

|                                      |  |                  |                            |  |                   |
|--------------------------------------|--|------------------|----------------------------|--|-------------------|
|                                      |  |                  |                            | DATE   |                   |
| PATIENT NAME - FIRST                 |  | MIDDLE           |                            | LAST   |                   |
|                                      |  |                  |                            | SEX<br><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, Doull, Galan, Gietzen, Hegewald, Koziara, Sanford, Tietjen and Sue Coffin, PA-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