

Welcome To Our Office: GASTROENTEROLOGY ASSOCIATES OF SOUTHWEST FLORIDA, P.A.

Social Security #: _____ Patient Legal First Name (**Print**): _____
Middle Name (**Print**): _____ Last Name (**Print**): _____
Sex M F Date of Birth: ___/___/___ Marital Status: Married Single Divorced Widowed Other Race _____
Primary Language: English Spanish Other: _____ Employment Status: Employed Part Time Student Retired
Patient Home Address: _____ City _____ State _____ Zip _____
Home Phone # _____ Work Phone # _____ Ext. _____ Mobile Phone# _____
Employer Name: _____ Employer Address: _____ Dept. _____
Alternative/Northern Address: _____ City _____ State _____ Zip _____ Dates at this Address: _____
Internet Access: Y N E-mail: _____ Preferred Communication: (check one) Secure Email or Paper
Check the physician: Sharma Feiock Longendyke Weiss Bays Raju Koka Hazan Perez Garner Other: _____
Family/Referring Physician Name: _____ Other Physicians: _____
How did you hear about us? Referring Doctor Friend / Family Yellow Pages Referral Program TV Commercial Paper/Magazine Ad

If on an HMO who is your primary care physician? _____
Primary Insurance Name: _____ Secondary Insurance Name: _____
Are you the policyholder for your primary insurance? Yes No (If No fill in below)
Policyholder's Name: _____ Date of Birth: ___/___/___ Soc.Sec#: _____ Relationship: _____
Are you the policyholder for your secondary insurance? Yes No (If No fill in below)
Policy Holder's Name: _____ Date of Birth: ___/___/___ Soc.Sec#: _____ Relationship: _____

Emergency Contact Name: _____ Sex: _____ Date of Birth: ___/___/___ Relationship: _____
Emergency Contact Home Phone: _____ Work Phone: _____ Mobile Phone: _____

What pharmacy do you use: _____ Pharmacy Phone: _____
Pharmacy Address: _____ City _____ State _____ Zip _____

By signing this form, you acknowledge all the above information is correct and accurate. By signing this form, you are granting consent to Gastroenterology Associates of S.W. Florida, P.A. and Barkley Surgicenter, Inc., to use and disclose your protected health information for purposes of treatment, payment, and health care operations. I authorize the release of my medical records to any physicians to whom I am referred. I acknowledge that a copy of the Privacy Notice has been made available to me.

Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by calling our office at (239) 275-8882. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent. A copy of this form is to be considered valid as an original.

Gastroenterology Associates of S.W. Florida, PA complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-954-735-6000 ext 4113. Haitian Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-954-735-6000 ext 4113.

Signed: _____ Date: _____