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 ☐ Zavala ☐ Fernandez

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

Type of Insurance Plan: ☐ HMO ☐ PPO ☐ POS ☐ Medicare ☐ Military ☐ Medicaid ☐ Self Pay ☐ Other:_____

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 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, age, disability, or sex.

Signed:_____Date_____