

LAST NAME FIRST NAME M.I

DATE OF BIRTH GENDER SS#

ADDRESS

CITY STATE ZIP CODE

PLEASE CIRCLE:

MARITAL STATUS: SINGLE | MARRIED | SEPARATED | DIVORCED | WIDOWED |

RACE: WHITE | AFRICAN AMERICAN | HISPANIC | ASIAN OR PACIFIC ISLANDER | NATIVE AMERICAN | ALASKAN NATIVE | NATIVE HAWAIIAN

OTHER(REFUSED): _____

HOME: _____ CELL: _____ CARRIER: _____

EMAIL: _____

PATIENT'S EMPLOYER: _____ OCCUPATION _____

SPOUSE'S NAME: _____ PHONE: _____

EMERGENCY CONTACT: _____ PHONE: _____

EMERGENCY CONTACT: _____ PHONE: _____

PRIMARY CARE: _____ PHONE: _____

GASTROENTEROLOGISTS: _____ PHONE: _____

ENT: _____ PHONE: _____

REFERRED BY: _____ PHONE: _____

INSURANCE INFORMATION:

PRIMARY INSURANCE: _____ ID#: _____ GROUP: _____

ADDRESS: _____

******IF YOU ARE NOT THE PRIMARY POLICY CARDHOLDER, WE NEED THE FOLLOWING INFORMATION******

PRIMARY CARDHOLDER NAME: _____ DOB: _____ SSN: _____

SECONDARY INSURANCE: _____ ID#: _____ GROUP: _____

***I GIVE PERMISSION TO GOPAL GRANDHIGE, MD TO ADMINISTER MEDICAL TREATMENT TO ME AND AUTHORIZE THE RELEASE OF ALL MEDICAL INFORMATION NECESSARY FOR MY TREATMENT.**

SIGN: _____ DATE: _____

***I AUTHORIZE THE RELEASE OF MY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS AN INSURANCE CLAIM. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO GO DIRECTLY TO SOUTH FLORIDA SURGICAL SPECIALISTS, LLC. I AUTHORIZE PHOTOCOPIES OF THIS FORM TO BE VALID AS THE ORIGINAL.**

SIGN: _____ DATE: _____

***BY SIGNING BELOW, YOU ARE GIVING PERMISSION TO BE CONTACTED VIA INTERNET BY SOUTH FLORIDA SURGICAL SPECIALISTS,**

SIGN: _____ DATE: _____

PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED