Patient Information

Referring Physician		Primary Care Physician		
Last Name	First Name	MI	Date of Birth	
Address	City		State	Zip
Home Phone ☐ Primary Number	Mobile Phone ☐ Primary Number	Work Phone ☐ Primary Number		
Social Security Number	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner			
Voicemail Messages on Home Phone Detailed Brief	Voicemail Messages on Mobile Phone ☐ Detailed ☐ Brief	Voicemail Messages on Work Phone ☐ Detailed ☐ Brief		
Emergency Contact Name	Emergency Contact Phone Number	Emergency Contact Relationship		
Email Address		☐ I consent for patient portal access		
Pharmacy Name	Pharmacy Location	Pharmacy Phone Number		

Insurance

Primary Insurance Company	Policy ID Number	Group Number
Subscriber Name	Relationship to Patient	Subscriber Date of Birth
Secondary Insurance Company	Policy ID Number	Group Number
Subscriber Name	Relationship to Patient	Subscriber Date of Birth

☐ I would like to add or change my personal representative information

Consent for Medical Treatment:

I, the undersigned, as the patient (or the patient's duly authorized representative) do hereby voluntarily consent to and authorize medical care encompassing all diagnostic and therapeutic treatments considered necessary or advisable in the judgement of any physician, his assistants, or designees. All medical care and treatments will be discussed with me, by the physician prior to any proposed treatments, testing, or medical procedures being scheduled. I am aware that the practice of medicine and surgery is not an exact science. I acknowledge that no guarantees have been made to me as to the results of treatments or examinations performed.

Consent to Obtain External Prescription History

I understand Digestive Health Associates of Texas, P.A. utilizes electronic prescribing technology and participates with SureScripts. I understand that my prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years

Notice of Privacy Practices

I acknowledge that I have been given the opportunity to receive the Notice of Privacy Practices. This notice identifies how medical information about you may be used and disclosed, and how you can gain access to this information.

Assignment of Benefits:

I hereby authorize payment of medical benefits directly to Digestive Health Associates of Texas, PA for services rendered. I understand that I am responsible for all charges for services rendered, including services not covered by my insurance company. I agree that all amounts are due upon request and are payable to DHAT. I further understand that should my account become delinquent I shall pay the reasonable collection expenses. Authorization is hereby granted to release information to my insurance company to obtain payment for services and determining insurance benefits. A photocopy of this assignment is as valid as the original.

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Patient Signature Date