

Texas Digestive Disease Consultants

Today's date	Name of physi	cian you	are see	eing toda	У		
Last name of patient	First name						_ Middle Initial
Street address							
City	····			State _		ZIP	
Home Phone		Work p	ohone _				
Mobile phone		E-mail	addres	s			
Date of birth Age	Sex Marital status						
Social security number		Occup	ation				
Employed by							
Preferred method of contact (please circ	le one) Home	phone	Cell	Work	Portal	Letter	Declines to specify
Emergency contact		Relatio	onship to	o patient			
Home phone		Work p	ohone _				
Referred by	Referring physician phone						
Primary insurance		Insure	d name				
Relationship to patient	Insured DOB Insured SS					SSN	
ID#	Group	#			Insuran	ce phone	·
Employer name							
Secondary insurance		Insure	d name				
Relationship to patient	Insured DOB				Insured SSN		
ID#	Group #				Insurance phone		
Employer name							
	<i>,</i>						

I authorize the insurance listed above to pay directly to Texas Digestive Disease Consultants all benefits due me, as provided for in the above policy contract with the aforementioned company(ies). I will pay for all such charges that may be denied by the insurance company(ies) above mentioned. I hereby consent to receiving calls or texts on my mobile device.



I have reviewed this office's notice of privacy practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

I hereby consent to treatment rendered by Texas Digestive Disease Consultants, which could include in office procedures and injections.

Signature of Patient/Guardian/Personal Representative

Relationship to patient