TDDC
Texas Digestive Disease Consultants

Today's date_____ Name of physician you are seeing today _____

Last name of patient _____ First _____ Middle initial _____

Street address _____

City _____ State _____ Zip _____

Home phone_____ Work phone _____

Mobile phone _____ E-mail address _____

Preferred method of contact (please circle one): home # work # cell # US mail

Date of birth_____ Age _____ Sex _____ Marital status _____

Social security number _____

Employed by _____ Occupation _____

Emergency contact _____ Relationship _____

Home phone_____ Work phone _____

Referred by _____ Primary care physician _____

Primary insurance _____ Insured name _____

DOB_____ SSN _____ Relationship _____

ID # _____ Group # _____ Insurance phone _____

Employer name _____

Secondary insurance _____ Insured name _____

DOB_____ SSN _____ Relationship _____

ID # _____ Group # _____ Insurance phone _____

Employer name _____

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.

_____ _____

Signature of Patient or Personal Representative Date

I authorize the person(s) below to receive information regarding my medical care:

_____

Name/Relationship Name/Relationship

Agreement/Authorization Release

I authorize the release of any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or health practitioners. I authorize my insurance company to pay directly to the doctor. If my insurance company does not pay, I understand that I will be responsible for payment. I agree to call my doctor's office if my test results have not been called to me within two weeks of completion of endoscopy/ scopes, blood tests, stool tests, biopsies/pathology and/or x-rays. I understand that my doctor may have a vested interest in the endoscopy center where my procedure may be performed.

_____ _____

Signature of Patient or Guardian Date