



# Pediatric Gastroenterology & Nutrition of Tampa Bay

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## PATIENT INFORMATION

Patient Name:		Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	DOB: ___ / ___ / ___
Patient Address:		SS#:	
		Race: <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Declined	
		Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Declined	
Phone 1: ( )	<input type="checkbox"/> Home <input type="checkbox"/> Grandparent <input type="checkbox"/> Mom Cell <input type="checkbox"/> Mom Work <input type="checkbox"/> Dad Cell <input type="checkbox"/> Dad Work <input type="checkbox"/> Other: _____	Preferred Language:	
Phone 2: ( )	<input type="checkbox"/> Home <input type="checkbox"/> Grandparent <input type="checkbox"/> Mom Cell <input type="checkbox"/> Mom Work <input type="checkbox"/> Dad Cell <input type="checkbox"/> Dad Work <input type="checkbox"/> Other: _____	E-mail address:	

## GUARANTOR INFORMATION (PERSON FINANCIALLY RESPONSIBLE)

First Guarantor/Guardian :		Relationship to Patient:	
Address: <input type="checkbox"/> Check if same as patient		Second Guarantor/Guardian :	
		Relationship to Patient:	Social Security #:
Home Phone: ( )		Other Phone: ( )	
Social Security #:	Date of Birth:	Date of Birth:	
Employer:		Employer:	
Work: ( )	Extension:	Work: ( )	Extension:

## PRIMARY CARE PHYSICIAN

Physician Name:		State:	Zip:
Address:		City:	
Is this the referring Physician? <input type="checkbox"/> YES <input type="checkbox"/> NO		Phone #:	Fax#:
If No, please list the Referring M.D.:			
Pharmacy Name & Address:		Pharmacy Phone: ( )	

## INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Insured Person:	Insured Person:
Insured DOB:	Insured DOB:
Insured SS#:	Insured SS#:

I hereby authorize Thirus S. Arasu, MD, PA/dba Pediatric Gastroenterology & Nutrition of Tampa Bay to treat the patient listed above. I hereby authorize payment directly to the above name physicians of the amount due me in all pending claims for medical expenses payable under the terms of my insurance. I agree that any balance not covered by my insurance will be paid by me if the insurance determines it is my responsibility. I authorize any physician, hospital or clinic to provide full detail of my or my dependent medical history and treatment to the above names physician group. In addition, I authorize the physician group listed above to release any information necessary to assist the medical treatment and/or insurance payment.

<b>X</b>	
Signature of Parent / Guardian / Responsible Party	Date Signed