Pediatric Gastroenterology & Nutrition of Tampa Bay

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PATIENT INFORMATION

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

GUARANTOR INFORMATION (PERSON FINANCIALLY RESPONSIBLE)

First Guarantor/Guardian :	Relationship to Patient:	
Address: ☐ 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? ☐ YES ☐ 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 hearby authorize Thirus S. Arasu, MD, PA/dba Pediatric Gastroenterology & Nutrition of Tampa Bay to treat the patient listed above. I hearby 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.

X	
Signature of Parent / Guardian / Responsible Party	**Date Signed**