**Methodist Digestive Health Specialists**

**Patient Information**

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| Primary Care Doctor Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  Name: |  | Birth Date: |  | Age: |  |
|  | **First** | **Last** | **Middle Initial** |  |  |
| Sex: | M F | *Marital status*: | Single Married Divorced Widowed Other |
| Social Security#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  Ethnicity:  **( ) Hispanic or Latino ( ) Not Hispanic ( ) Decline to provide**

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| Race: ( )Caucasian ( )African-American ( ) Hispanic ( ) Asian ( )OtherDo you need an interpreter?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What is your preferred Language?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Preferred written language? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Religion? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **\*Home address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\*Employer**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\*In case of emergency contact**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\*Pharmacy Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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**Insurance Information**

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| **Primary insurance:** |  |
| Insured’s name: |  | Birth date: |  |
| Claim form address: |  | City: |  | State: |  | Zip Code: |  |
| Insured’s ID #: |  | Group #: |  | Phone: |  |
| **Secondary insurance:** |  |
| Insured’s name: |  | Birth date: |  |
| Claim form address: |  | City: |  | State: |  | Zip Code: |  |
| Insured’s ID #: |  | Group #: |  | Phone: |  |

**Signature of Patient or Guradian**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_