TDDC
Texas Digestive Disease Consultants

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

Last name of patient _____ First name _____ Middle Initial _____

Street address _____

City _____ State _____ ZIP _____

Home Phone _____ Work phone _____

Mobile phone _____ E-mail address _____

Date of birth _____ Age_____ Sex _____ Marital status _____

Social security number _____ Occupation _____

Employed by _____

Preferred method of contact (please circle one) Home phone Cell Work Portal Letter Declines to specify

Emergency contact _____ Relationship to patient _____

Home phone _____ Work phone _____

Referred by _____ Referring physician phone _____

Primary insurance _____ Insured name _____

Relationship to patient _____ Insured DOB _____ Insured SSN _____

ID# _____ Group # _____ Insurance phone _____

Employer name _____

Secondary insurance _____ Insured name _____

Relationship to patient _____ Insured DOB _____ Insured SSN _____

ID# _____ Group # _____ Insurance phone _____

Employer name _____

☐ 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 Date

_____ _____

Name of Guardian/Personal Representative (please print) Relationship to patient