Digestive
SURGERY CENTER

RAUL RAMOS, MD., F.A.C.S.

Name Last	First	Initial	Birth Date	Age	Sex
Address	Apt#	City	State		Zip
Home Phone#	Work Phone#	Ext.	Cell Phone		E-Mail

Patient SS# | Drivers License # State | Employer Name & Address

Martial Status S M D W SEP | Spouse/Parent Name | Spouse/Parent/Emp | Work Phone #

Referring Physicians Name, Address & Phone # | Primary care Physicians Name, Address

Method of Payment: _______ Cash _______ Check _______ Master Card, Visa, or AE

Emergency Contact | Relationship To Patient

Home Phone # | Work Phone # | Cell Phone #

Primary Ins. Co. Name | Ins. Address, City, St., Zip | Ins. Phone #

Policy # | Group # | Policy Holder Name / Date of Birth / SS #

Secondary Ins. Co. Name | Ins. Address, City, St., Zip

Policy # | Group # | Policy Holder Name / Date of Birth / SS #

RELEASE OF INFORMATION AUTHORITY AND/OR ASSIGNMENT OF INSURANCE BENEFITS:
I understand that any and all information in my medical records is confidential and will only be released to physicians, insurance companies and/or the health care financing organization and its agents, whom I have given authorization. I also authorize payment of approved insurance or medicare benefits to be made directly to this medical practice and permit a copy of this authorization to be used in place of the original. I authorize my insurance company or the health care financing organization to provide this medical practice any information that will assist them in collecting benefits. I understand this information may contain information relating to:

Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV (Human Immunodeficiency Virus), Mental Health, Alcohol And / or Drug Abuse

REVOCATION: I UNDERSTAND THAT THIS AUTHORIZATION MAY BE REVOKED IN WRITING AT ANY TIME. EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE ON THIS AUTHORIZTION FOR THE PURPOSES STATED ABOVE.

I understand that there may be a fee for preparing and furnishing this information.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE | RELATIONSHIP TO PATIENT | DATE

Alcohol & Drug Abuse Records: This information may have been disclosed to you from records whose confidentiality is protected by Federal Law Federal Regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical and other records information is not sufficient for this purpose. Original or copy of this authorization shall be filed in the patient's medical record.