



520 E. Euclid Avenue, San Antonio, TX 78212

DDT INS INC SS SE NE BO
Office: 210-271-0606 Fax: 210-226-8838

<input type="checkbox"/> Dr. Ernesto Guerra, Jr.	<input type="checkbox"/> Dr. Belinda Ramirez	ACCOUNT NUMBER: _____
<input type="checkbox"/> Dr. Richard L. Otero	<input type="checkbox"/> Dr. Eddie Flores	
<input type="checkbox"/> Dr. Steven R. Ramos	<input type="checkbox"/> Dr. Michael S. Lindner	<input type="checkbox"/> New Patient
<input type="checkbox"/> Dr. Joseph E. Johnson	<input type="checkbox"/> Dr. Jeff S. Bullock	<input type="checkbox"/> Established Patient

Patient's Last Name: _____ First Name: _____ MI: _____
 Street Address: _____ City: _____ State: _____ ZIP: _____
 Home Phone: _____ Cell Phone: _____ Work Phone: _____
 Email Address: _____ Primary Language: _____
 Sex: M F Marital Status: Single Married Long-Term Partner Divorced Widowed Separated
 Date of Birth: ____/____/____ Social Security Number: ____-____-____ Driver's License #: _____ State: ____
 Employer Name: _____ Employer Phone: _____
 Employer Street Address: _____ City: _____ State: _____ ZIP: _____
 Spouse Name: _____ Date of Birth: ____/____/____ Social Security #: ____-____-____
 Spouse Employer Name: _____ Spouse Employer Phone: _____
 Employer Street Address: _____ City: _____ State: _____ ZIP: _____

In case of Emergency, whom should we contact? _____ Phone: _____

Who should we thank for referring you to our practice? _____

Insurance Information – A Copy of your Insurance Card(s) and Driver's License (photo ID) is Required

Primary Insurance: _____ Phone: _____
 Policy Holder Name: _____ Policy ID: _____ Group #: _____
 Secondary Insurance: _____ Phone: _____
 Policy Holder Name: _____ Policy ID: _____ Group #: _____

Communication Authorization – Please Complete

We are committed to providing private and efficient communication with you. Please indicate the preferred method(s) of contact, should we need to reach you by phone. Place an "X" in the appropriate box(es).

<input type="checkbox"/> Home	<input type="checkbox"/> message to return call	<input type="checkbox"/> detailed message (results,treatment)	<input type="checkbox"/> NO Message	<input type="checkbox"/> voice mail	<input type="checkbox"/> with an individual
<input type="checkbox"/> Work	<input type="checkbox"/> message to return call	<input type="checkbox"/> detailed message (results,treatment)	<input type="checkbox"/> NO Message	<input type="checkbox"/> voice mail	<input type="checkbox"/> with an individual
<input type="checkbox"/> Cellular	<input type="checkbox"/> message to return call	<input type="checkbox"/> detailed message (results,treatment)	<input type="checkbox"/> NO Message	<input type="checkbox"/> voice mail	<input type="checkbox"/> with an individual

In certain instances, it may be necessary to communicate via email. Yes – Email No – Email

Release of Information Policy – Please Read

I hereby authorize San Antonio Gastroenterology Associates, P.A. to use and /or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and other health care operations. My protected health information may be released to the following individual(s):

Name: _____	DOB: _____	Relationship to Patient: _____
Name: _____	DOB: _____	Relationship to Patient: _____
Name: _____	DOB: _____	Relationship to Patient: _____
Name: _____	DOB: _____	Relationship to Patient: _____

Notice of Privacy Practices

I acknowledge that I have been provided the "Notice of Privacy Practices" for San Antonio Gastroenterology Associates, P.A..

I acknowledge that I have completed this form and certify that I am the patient or duly authorized to furnish the information requested.

_____ Date _____ Signature of Patient or Responsible Party