

Narciso L. Gomez, MD, FACS, FASCRS

BOARD CERTIFIED

COMPASSIONATE SURGICAL CARE

TEL: (954) 369-5717

FAX: (954) 827-0717

INFO@GOMEZSURGICAL.COM

WWW.GOMEZSURGICAL.COM

3475 SHERIDAN STREET

SUITE 201

SHERIDAN EXECUTIVE CENTRE

HOLLYWOOD, FL 33021

PATIENT INFORMATION FORM

PATIENT NAME _____ SEX ___MALE ___FEMALE
 SOCIAL SECURITY # _____ BIRTHDATE _____ AGE ___ MARITAL STATUS ___S ___M ___W ___D
 HOME PHONE NUMBER (____) _____ CELL PHONE NUMBER (____) _____
 E MAIL ADDRESS _____
 STREET ADDRESS _____ APT. _____
 CITY _____ STATE _____ ZIP _____
 OCCUPATION _____ EMPLOYER _____ EMPLOYER PHONE (____) _____
 SPOUSE NAME _____ BIRTHDATE _____
 REFERRED BY: _____

SOMEONE TO CONTACT LOCALLY IN CASE OF EMERGENCY, OTHER THAN SOMEONE LIVING WITH YOU:

NAME _____ PHONE (____) _____ RELATIONSHIP _____
 ADDRESS _____ CITY _____ STATE _____ ZIP _____

PRIMARY CARE/MEDICAL DOCTOR: _____ PHONE (____) _____ FAX (____) _____
 CARDIOLOGIST: _____ PHONE (____) _____ FAX (____) _____

PRIMARY INSURANCE INFORMATION

INSURANCE CO. _____
 I.D. # _____ GROUP# _____
 PRIMARY INSURED _____
 PRIMARY INSURED SOCIAL SECURITY # _____
 PRIMARY INSURED D.O.B. _____
 RELATIONSHIP TO INSURED _____
 (SELF - HUSBAND - WIFE - CHILD - OTHER)

SECONDARY INSURANCE INFORMATION

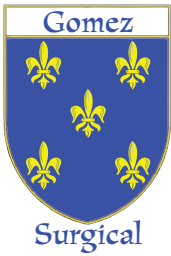
INSURANCE CO. _____
 I.D. # _____ GROUP# _____
 PRIMARY INSURED _____
 PRIMARY INSURED SOCIAL SECURITY# _____
 PRIMARY INSURED D.O.B. _____
 RELATIONSHIP TO INSURED _____
 (SELF - HUSBAND - WIFE - CHILD - OTHER)

GUARANTEE OF PAYMENT

I fully understand that I am directly responsible for payment to the Physicians in this office for all medical services rendered to me. I also understand that all bills are payable and become due at the time services are rendered, unless other arrangements have been made. I agree to pay all collection costs including reasonable attorney's fees and costs in the event it becomes necessary to file suit to effect payment. I authorize payments to be made directly to my doctor.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the Physicians in this office to release any information acquired in the course of my examination or treatment to my insurance company for the purpose of processing any insurance claim.



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Authorization to Discuss Protected Health Information

I, _____, authorize _____
to release or discuss information related to my medical condition (including information
related to my treatment plan, medication information and/or billing information) to the
following named persons**:

1. _____
2. _____
3. _____
4. _____

- * PLEASE BE ADVISED THAT ANY PERSON NOT REFERRED TO ON THIS LIST WILL NOT BE GIVEN ANY INFORMATION RELATED TO YOUR CARE, INCLUDING BILLING INFORMATION. YOU MAY CHANGE, RESTRICT OR EXPAND THIS LISTING AT ANY TIME.
- * YOU ARE NOT REQUIRED TO LIST ANY NAME IF YOU DO NOT SO CHOOSE.

Please list phone numbers where you would like us to contact you for:

- Results, reminder notices, changes on scheduled appointments, and returned phone calls, etc.....

1. _____
2. _____

Patient Signature: _____ Date: _____

ADVANCE DIRECTIVE