Gomez Surgical

Narciso L. Gomez, MD, FACS, FASCRS
Board Certified
Compassionate Surgical Care
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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. _____ 3. _____

2. _____ 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