PATIENT REGISTRATION FORM
Westside Gastrointestinal Specialists, PLLC
Jeffrey R. Crist, M.D. & Juan Benitez, M.D.

Please print all information in the spaces provided. Be sure to complete and sign all statements on the back page of this form.

PATIENT INFORMATION: **TODAY'S DATE:**

First Name: _____ MI:_____ Last Name:_____

Home Address: _____

City, State, Zip: _____

Social Security Number: _____ Date of Birth: ____/____/____ Sex: M / F

Marital Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐

Preferred Phone Home or Cell or Other (please circle)

Home Phone: (____) _____ Cell Phone: (____) _____ Other: _____

Primary Care Physician: _____ Source of Referral:_____

EMERGENCY CONTACT:

Name:_____ Relation: _____

Home Phone: (_____)_____ Alternate: (_____) _____

EMPLOYMENT INFORMATION:

Employment Status: Employed ☐ Disabled ☐ Retired ☐ Unemployed ☐ Student ☐ Self ☐

Employer Name: _____ Occupation: _____

Work Phone: (_____) _____

INSURANCE INFORMATION: *Please provide your Insurance card(s) to the Receptionist*

Primary Insurance Company: _____

Insured/ Card Holder's Name: _____ Relationship: _____

Date of Birth: ____/____/____ Social Security Number: _____

Secondary Insurance Company: _____

Insured/ Card Holder's Name: _____ Relationship: _____

Date of Birth: ____/____/____ Social Security Number: _____

(OVER)

FINANCIAL RESPONSIBILITY

I hereby authorize payment of medical benefits billed to my insurance to Westside Gastrointestinal Specialists (for Jeffrey R. Crist, MD or Juan Benitez, MD).

I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance, if the Practice does not participate with my insurance. If my account becomes delinquent, I understand that I can be billed for (35%) collection or attorney's fees necessary to collect payment. I may also be billed a 1½ % monthly service charge for a delinquent account. I agree to pay all co-payments, coinsurance, and deductibles at the time the service is rendered unless previous financial arrangements are made.

_____ _____

Signature of patient or guarantor Date

DO YOU HAVE TENNCARE COVERAGE? **Yes or No**

HAVE YOU APPLIED FOR TENNCARE COVERAGE? **Yes or No**

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I, _____, hereby authorize Westside Gastrointestinal Specialists 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 health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Westside Gastrointestinal Specialists can refuse to treat me.

I have been informed that Westside Gastrointestinal Specialists has prepared a "Notice" which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying Westside Gastrointestinal Specialists, in writing, but if I revoke my consent, such revocation will not affect any actions that Westside Gastrointestinal Specialists took before receiving my revocation.

I understand that Westside Gastrointestinal Specialists has reserved the right to change their privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that Westside Gastrointestinal Specialists restrict how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that Westside Gastrointestinal Specialists does not have to agree to such restrictions, but that once such restrictions are agreed to, Westside Gastrointestinal Specialists must adhere to such restrictions.

_____ _____

Signature of patient or patient's representative Date

_____ _____

Printed name of patient or patient's representative Relationship to patient

Please list anyone other than yourself or your family doctor that we may speak to or release information to on your behalf.

_____ _____

Name of person Relationship to patient

_____ _____

Signature of patient or patient's representative Date

_____ _____

Printed name of patient or patient's representative Relationship to patient

Revised 12-12-12