Check One:
☐ New Patient
☐ Established Patient

DLDSA Patient Check In Forms

Patient's Last Name: ____________________________________ **First Name:** _________________________ **MI:**___

Street Address: ____ C/S/Z: _____________________________________

Phone: Home: __________________________________ Cell: _________________________ Work: ________________________

Email Address: ____ Primary Language: _______________________________

Race: ☐ American Indian or Alaska ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander

☐ White ☐ Declined to Specify

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to Specify

Sex: ☐ M ☐ F **DOB**: __________ **Marital Status:** ☐ Single ☐ Married ☐ Long-Term Partner ☐ Divorced ☐ Widowed ☐ Separated

SSN:_____________________ Driver License #__________________________ State: _______

Emergency Contact Information:

Name of Person:______________________________ **Relationship**:_____________________ **Best Phone**:___________________

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

Are you the Guarantor: ☐ Yes ☐ No

Primary Insurance: ____ Phone: __________________________

Policy Holder Name: ______________________________Policy ID: __________________________ Group #:________________

Secondary Insurance: ____Phone: __________________________

Policy Holder Name: _________________________________Policy ID: __________________________ Group #:________________

Guarantor information:

Primary Insurance: ____ Phone: __________________________

Policy Holder Name: ______________________________Policy ID: __________________________ Group #:________________

Secondary Insurance: ____Phone: __________________________

Policy Holder Name: _________________________________Policy ID: __________________________ Group #:________________

Patients Employment Information:

Employer Name____ Employer Phone: ______________________________

Partners Employment Information:

Partners Name: ____ DOB: _________________ SSN: ______________________

Partners Employer Name____ Partners Employer Phone: _________________________

Preferred Patient's Pharmacy:

Pharmacy Name____ Pharmacy Phone: ______________________________

Patient's Last Name: ______________________________________ **First Name:** __________________________ **MI:**___

Communication Authorization – Please Complete

We are committed to providing private and efficient communication with you. Please indicate your preferred method (s) of contact, "X" in Box(es):

☐ Home	☐ Message to return call	☐ Detailed message (results, treatment)	☐ No Message	☐ Voicemail	☐ with Individual
☐ Work	☐ Message to return call	☐ Detailed message (results, treatment)	☐ No Message	☐ Voicemail	☐ with Individual
☐ Cell	☐ Message to return call	☐ Detailed message (results, treatment)	☐ No Message	☐ Voicemail	☐ with Individual

By initialing below, Patient consents to receive autodialed calls, emails, and /r text message, and prerecorded calls, emails and/ or text messages from or on behalf of DLDSA and any of its affiliates at any telephone number provided to DLDSA, including wireless numbers, if applicable, regarding any appointments, procedures, debt payments, promotional material, advertisement, special offers, circulars or any such marketing material that may not be offered by DLDSA or any of its affiliates, Initial:_________

Release of Information Policy- Please Read

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

Name	DOB	Relationship to Patient

I acknowledge I have been Provided the "Notice of Privacy Practices" for DLDSA. I acknowledge I have completed this form and certify that I am the patient or duly authorized to furnish the information requested.

Patient or Responsible Party Signature ______________________ Date ______________

Digestive & Liver Disease Center of San Antonio, PLLC was unable to obtain acknowledgement because:

Reason: ____

Staff Signature ______________________ Date ______________