Pediatric Gastroenterology & Nutrition of Tampa Bay

Main Office
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PATIENT INFORMATION

Patient Name:	Gender: ☐Female ☐Male	DOB: ____/____/____
Patient Address:	SS#:	
	Race: ☐ White/Caucasian ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐Declined	
	Ethnicity: ☐ Hispanic or Latino ☐Not Hispanic or Latino	
Phone 1: ( ) ☐ Home ☐Grandparent ☐ Mom Cell ☐Mom Work ☐ Dad Cell ☐ Dad Work ☐ Other:	Preferred Language:	
Phone 2: ( ) ☐ Home ☐Grandparent ☐ Mom Cell ☐ Mom Work ☐ Dad Cell ☐ Dad Work ☐ Other: _____	E-mail address:	

GUARANTOR INFORMATION (PERSON FINANCIALLY RESPONSIBLE)

Guarantor/Guardian :	Relationship to Patient:	
Address: ☐ Check if same as patient	Pharmacy Name & Address:	
Home Phone: ( )	Pharmacy Phone: ( )	
Social Security #:	Date of Birth:	Other Parent/Guardian:
Employer:	Work: ( )	Extension:

PRIMARY CARE PHYSICIAN

Physician Name:			
Address:	City:	State:	Zip:
Is this the referring Physician? ☐YES ☐NO	Phone #:		Fax#:

If No, please list the Referring M.D.:

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Insured Person:	Insured Person:
Insured DOB:	Insured DOB:
Insured SS#:	Insured SS#:

I hereby authorize Thiru S. Arasu, MD, PA/dba Pediatric Gastroenterology & Nutrition of Tampa Bay to treat the patient listed above. I hereby authorize payment directly to the above name physicians of the amount due me in all pending claims for medical expenses payable under the terms of my insurance. I agree that any balance not covered by my insurance will be paid by me if the insurance determines it is my responsibility. I authorize any physician, hospital, or clinic to provide full detail of my or my dependent medical history and treatment to the above named physicians. In addition, I authorize the physician's listed above to release any information necessary to assist in medical treatment and / or insurance payment.

X	
Signature of Parent / Guardian / Responsible Party	**Date Signed**