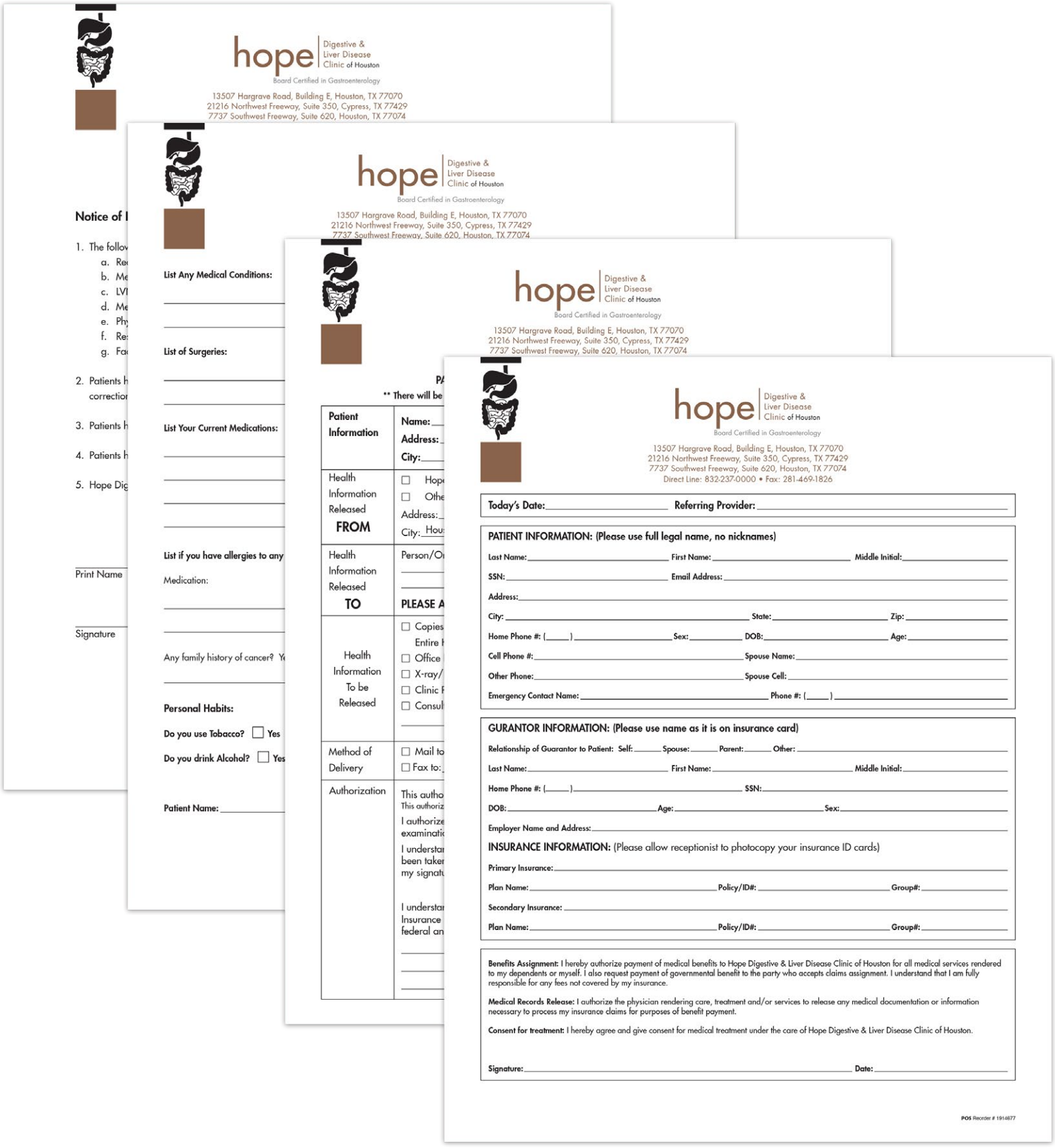

hope Digestive & Liver Disease Clinic of Houston
Board Certified in Gastroenterology
13507 Hargrave Road, Building E, Houston, TX 77070
21216 Northwest Freeway, Suite 350, Cypress, TX 77429
7737 Southwest Freeway, Suite 620, Houston, TX 77074
Direct Line: 832-237-0000 • Fax: 281-469-1826

Today's Date: _____ Referring Provider: _____

PATIENT INFORMATION: (Please use full legal name, no nicknames)

Last Name: _____ First Name: _____ Middle Initial: _____
SSN: _____ Email Address: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone #: (____) _____ Sex: _____ DOB: _____ Age: _____
Cell Phone #: _____ Spouse Name: _____
Other Phone: _____ Spouse Cell: _____
Emergency Contact Name: _____ Phone #: (____) _____

GURANTOR INFORMATION: (Please use name as it is on insurance card)

Relationship of Guarantor to Patient: Self: ____ Spouse: ____ Parent: ____ Other: _____
Last Name: _____ First Name: _____ Middle Initial: _____
Home Phone #: (____) _____ SSN: _____
DOB: _____ Age: _____ Sex: _____
Employer Name and Address: _____

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance ID cards)

Primary Insurance: _____
Plan Name: _____ Policy/ID#: _____ Group#: _____
Secondary Insurance: _____
Plan Name: _____ Policy/ID#: _____ Group#: _____

Benefits Assignment: I hereby authorize payment of medical benefits to Hope Digestive & Liver Disease Clinic of Houston for all medical services rendered to my dependents or myself. I also request payment of governmental benefit to the party who accepts claims assignment. I understand that I am fully responsible for any fees not covered by my insurance.

Medical Records Release: I authorize the physician rendering care, treatment and/or services to release any medical documentation or information necessary to process my insurance claims for purposes of benefit payment.

Consent for treatment: I hereby agree and give consent for medical treatment under the care of Hope Digestive & Liver Disease Clinic of Houston.

Signature: _____ Date: _____

POS Reorder # 1914677

Notice of I

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3. Patients h
4. Patients h
5. Hope Dig

Print Name

Signature

List Any Medical Conditions:

List of Surgeries:

List Your Current Medications:

List if you have allergies to any

Medication:

Any family history of cancer? Y

Personal Habits:

Do you use Tobacco? ☐ Yes

Do you drink Alcohol? ☐ Yes

Patient Name: _____

** There will be

Patient Information	Name: _____ Address: _____ City: _____
Health Information Released **FROM**	☐ Hope ☐ Othe Address: _____ City: Hou:
Health Information Released **TO**	Person/O _____ _____ **PLEASE A**
Health Information To be Released	☐ Copies Entire H ☐ Office ☐ X-ray/ ☐ Clinic F ☐ Consul _____
Method of Delivery	☐ Mail to ☐ Fax to:
Authorization	This autho This authoriz I authorize examinati I understar been taker my signatu I understar Insurance federal an _____ _____ _____