Florida Digestive Health Specialists
Constantine G. Marousis, MD
1950Arlington St. Suite 101
Sarasota, FL 34239
(941) 366-1400

PATIENT REGISTRATION

Male _________ Female _________ E-Mail address ________________________________ Marital Status S M D W other

Name____ SS# ______-______-______ Date of birth ____/____/_____

Address #1____ City__________________ State______ Zip____________
(No PO Box's please)
Telephone Home (_____) _____-_________ Work (______) _______-_________ Cell (_____) ______-___________

Address #2____City___________________ State______Zip_____________
(Northern Address)
Spouse Name ____

Emergency contact______________________________________ Telephone (_____) ______-________Relationship____________

Referring Doctor or Family Physician ____

PRIMARY INSURANCE:

Company Name _____________________________________ Telephone (_____) ______-________

ID#__________________________________ Group#___________________

SUBSCRIBER OF INSURANCE (if different then patient):

Name________________________________ Date of birth ____/_____/_____ Relationship ___________

SECONDARY INSURANCE:

Company Name _____________________________________Telephone (____) _____-______

ID#_________________________________ Group#___________________

EMPLOYER INFORMATION:

Employer Name ____________________________________ Telephone (_____) ______-________

Address _____________________________________City ____________________St______Zip_________

AUTHORIZATION AND ASSIGNMENT OF BENEFITS:

I authorize the release of any medical information necessary to process my claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.
I hereby authorize Dr. Constantine Marousis to apply for benefits on my behalf for covered services rendered by him or by his order.
I request that payment from my insurance company be made directly to Dr. Constantine Marousis (or to the party who accepts assignment).
I certify that the information I have reported with regard to my insurance coverage is correct.
I understand that my insurance carrier may pay less than the actual bill for services rendered. I agree to be responsible for the payment of all services rendered on my behalf or my dependants. I agree to pay any collection fees, including reasonable attorney fees if necessary to collect my debt.

_____________________________________ ______/_______/________
Signature (Patient, Parent, or Guardian) **Date**

Revised 7/08/2003

REMEMBER TO SIGN NOTICE OF PRIVACY CONSENT FORM (over)

MEDICAL HISTORY

Florida Digestive Health Specialists
Constantine G. Marousis, M.D.

Sarasota, FL 34239

Name:____

Age:_______________ HT: ____________ WT :________________
Male ______ Female______

Please indicate by a check mark ( ) YES or NO to EACH question below:
Do you now or have you ever had any of the following:

ENDOCRINE SYSTEM:	YES	NO	COMMENTS
Diabetes			
Thyroid Trouble			
Low Blood Sugar			
Other			
CARDIOVASCULAR SYSTEM:			
Murmur			
Prolapsed Valve			
Chest Pain/Angina			
Palpitations/Heart Attack			
Arrythmia/Fibrillation			
Congestive Heart Failure			
Elevated Cholesterol			
High Blood Pressure			
Low Blood Pressure			
Other			
PULMONARY SYSTEM:			
Shortness of Breath			
Emphysema			
Asthma			
Hay Fever			
Chronic Cough			
Bronchitis			
Pneumonia			
Tuberculosis			
Other			
GASTROINTESTINAL SYSTEM:			
Difficulty Swallowing			
Food Sticking			
Heartburn			
Reflux			
Esophageal Stricture			
Ulcer			
Gallbladder/Disease			
Colon Polyps			
Hiatal Hernia			
Other			
PERIPHERAL VASCULAR SYSTEM:			
Claudication			
Swelling of Extremities			
Other			

GENITOURINARY SYSTEM:	YES	NO	COMMENTS
Urinary Tract Infection			
Kidney Disease			
Dialysis			
Other			
NEUROLOGIC SYSTEM:			
Dizziness			
Fainting			
Seizures/Epilepsy			
Blurred Vision			
Other			
CEREBROVASCULAR SYSTEM:			
Stroke			
Transient Ischemic Attack			
Carotid Surgery			
Other			
MUSCULOSKELETAL SYSTEM:			
Arthritis			
Gout			
Muscle Pain			
Back Pain/Injury			
Other			
HEMATOLOGIC SYSTEM:			
Anemia			
Fatigue			
Sickle Cell Anemia			
Jaundice/Hepatitis			
Blood Transfusions			
Bleeding Problems			
Liver Problems/Alcoholism			
Other			
INTEGUMENT (SKIN):			
Skin Cancer			
Other			

LIST ALLERGIES:	CURRENT MEDICATIONS:
1	1
2	2
3	3
4	4
5	5
6	6
7	7
	8
	9
	10

DO YOU ? Please circle Yes or No

ALCOHOL: Y Y OR N Type_____Amount per day______per wk_______per mon._______

SMOKE: Y OR N Packs per Day__________ How long_________

COFFEE: Y OR N Cups per Day __________ Other Caffeine________________

UNUSUAL REACTION TO ANESTHESIA YES or NO Comments

PLEASE LIST ALL SURGERIES ON BACK:

PATIENTS SIGNATURE DATE

PHYSICIANS SIGNATURE DATE

FLORIDA DIGESTIVE HEALTH SPECIALISTS
CONSTANTINE G. MAROUSIS, MD
1950 Arlignton ST. SUITE 101
SARASOTA, FL 34239
941-366-1400 FAX 941-366-1913

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS
PLEASE READ AND COMPLETE THE ENTIRE FORM

***This notice describes how medical information about you may be used and disclosed and how you can get access to this information. PLEASE REVIEW CAREFULLY.**

Patient Name:________________________________ Date of Birth ____/____/____

Do we have your permission to:
Send appointment reminders to your home? Y or N
Send test results to your home? Y or N
Do we have permission to leave the following on your home answering/voice mail:
Appointment information Y or N
Billing information Y or N
Medical information (ie: Lab results) Y or N

I give permission to share appointment, billing and medical information with the person(s) named below:
Name:____________________________________ Relationship: ____________
Name: ____________________________________ Relationship: ____________

I authorize the office of **Constantine G. Marousis, MD** to**: Send** or **Obtain** my medical records to/from the following physicians below:

1. ________________________________ 4. ________________________________

2. ________________________________ 5. ________________________________

3. ________________________________ 6. ________________________________

- I understand that my medical records may contain information about but not limited to: alcohol and/or drug treatment, mental health or psychiatric, and/or HIV/AIDS information. I do herein expressly and voluntarily consent to the disclosure of my health information, as specified, for the purpose or need indicated above.
- **I understand that if I choose to add anyone else to this list I must sign another release form and that your office will not add any additional persons to this form**.
- I understand that in the case of an emergency my records will be sent out to the appropriate caregivers even though they may not be listed on this form.
- I understand that certain records may be sent via telefax and I relieve Constantine G. Marousis MD, his employees, and or agents any liability from mis-transmission by telefax.
- A photocopy of this authorization shall have the same effects as the original.

____ ________________
Patient Signature Date

Revised 1/27/04

Florida Digestive Health Specialists

CONSTANTINE G. MAROUSIS, MD
OFFICE FINANCIAL POLICY

COMMERCIAL INSURANCE PATIENTS:

Patients will be informed when they make their appointment of the fee range, when possible, for their office consultation. Patients are responsible at the time of service for any co-pay that they may have per their contract with the insurance company. The office will file their commercial insurance claim for them. Any approved amount not paid (ie; deductible, co-pay, out of pocket) will become the immediate responsibility of the patient.

SELF PAY PATIENTS:

Patients will be informed at the time they make their appointment of payment policy. A fee range, when possible, will be given, along with any anticipated additional charges. You will be required to give a credit card number to hold your appointment. If appointment is not cancelled there will be a $35.00 charge for a no show applied to your credit card. **The full cost of the office visit will be due at the time of service.**

MEDICARE PATIENTS WITHOUT SUPPLEMENTAL COVERAGE:

Patients will be informed at the time they make their appointment of the policy regarding Medicare and if possible, the fee range, plus any additional anticipated charges. **Any unpaid deductible, plus the 20% co-pay amount is due at the time of service**. The office will file a claim to Medicare for the balance.

MEDICARE PATIENTS WITH SUPPLEMENTAL COVERAGE:

Patients will be informed at the time they make their appointment of the policy regarding Medicare and if possible, the fee range, plus any additional anticipated charges. The office will file a claim to both to Medicare and the supplemental carrier for all charges. **Any approved amount not paid will become the immediate responsibility of the patient.**

AUTHORIZATION AND PRE-CERT:

This office will call your insurance for auth or pre-cert if needed on any outpatient testing. It is your responsibility as the patient to contact your insurance company regarding the co-pay or deductible that you may be responsible for.

Revised 8/29/07