Bach & Godofsky
Infectious Diseases

6010 Pointe West Blvd
Bradenton, FL 34209
P:(941) 746-2711 F:(941) 746-3433

PATIENT INFORMATION

Today's Date ____/_____/_____		
Date of Birth:	Social Security Number:	
Home Phone (_____)_____-_____	Mobile Phone(____)_____-_____	Work Number(____)_____-_____

Preferred Method of Contact: ☐Home Phone ☐Mobile Phone ☐Work Number ☐Email
Email for Portal Contact_____

EMERGENCY CONTACT/RELEASE OF MEDICAL INFORMATION

Name	Phone Number	☐Spouse ☐Partner ☐Parent ☐Child ☐Other_____

I authorize the practice of Bach & Godofsky to speak with the EMERGENCY CONTACT listed above and the additional INDIVIDUALS listed below regarding my Private Healthcare Information (PHI). ☐Yes ☐No

Name:	☐Spouse ☐Partner ☐Parent ☐Child ☐ Other_____
Name:	☐Spouse ☐Partner ☐Parent ☐Child ☐ Other_____
Name:	☐Spouse ☐Partner ☐Parent ☐Child ☐ Other_____

INSURANCE INFORMATION

☐Medicare	☐Commercial Insurance	☐Workers Comp/Auto Related	☐Self-Pay

Primary Insurance	Insured Name	Insured SSN	Insured DOB

Patient's Relationship to Insured: ☐Self ☐Spouse ☐Child ☐Other_____

Secondary Insurance ☐N/A	Insured Name	Insured SSN	Insured DOB

Patient's Relationship to Insured: ☐Self ☐Spouse ☐Child ☐Other_____

Tertiary Ins ☐N/A ☐Yes_____

LOCAL PHARMACY:	**MAIL ORDER PHARMACY:**	**LAB:**
_____	_____	☐**QUEST** ☐**LABCORP**
Address or Cross Streets:_____	Address_____	☐**Manatee Memorial**
City_____ St_____	City_____ St_____	☐**Blake Medical Center**
Zip_____	Zip_____	☐**Other**_____
Phone (____)_____-_____	Phone (____)_____-_____	☐**None Preferred**

HEALTH TEAM MEMBERS:
Primary Care Physician _____Phone(____)_____-_____
Referring Physician _____Phone(____)_____-_____
Other physicians that you see:
_____

☐ **PRIVACY STATEMENT ACKNOWLEDGEMENT: I have received the Patient Privacy Statement information from the practice of Bach & Godofsky. I am aware that the Patient Privacy Statement will be available for viewing in the office or via the Patient Portal.**

☐ **AUTHORIZATION TO DOWNLOAD MEDICATION HISTORY: I authorize the download of my medication history into the electronic medical records of Bach and Godofsky Infectious Diseases.**

☐ **PERMISSION TO COMMUNICATE VIA PATIENT PORTAL: I have reviewed the Bach & Godofsky Patient Portal Authorization form and agree to participate in the portal voluntarily.**

Check the above boxes as authorization and sign/date below.

Patient/Representative:_____**Date:**_____