Gastro Star
Dr. Desh B Sharma, MD
Board Certified Gastroenterology & Hepatology

# *Patient Information*

Date**:** _____

Last Name: _____, First Name _____

Address Include City, State, Zip

_____

_____

DOB: _____ Gender: M( ) F ( )

Martial Status: Single [ ] Married [ ] Divorced [ ] Widowed [ ]

Insurance Information :

Primary: _____

Secondary: _____

Social Security #: _____

Telephone Numbers: Mobile # (____)_____-_____

Home # (____)_____-_____

Email Address: _____

How do you prefer to be contacted?

( ) Mobile

( ) Email Address

## *Emergency Contact*

Name: _____

Relationship to patient: _____

3303 Rogers Road, Suite 250 San Antonio, TX 78251
Ph # 210-405-3410; Fax # 210-405-3411

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Primary Number: (_____)_____-_____

Secondary Number: (___)_____-_____

Drives License/ ID _____

Race: _____

Ethnicity:_____

Patient Employer: _____

Occupation:_____

## *Primary Care Information*

Name: _____

PCP (_____)_____-_____

## *Pharmacy Information*

Name:_____

Address & Phone/Fax Number: _____

_____

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# AUTHORIZATION TO RESLEASE MEDICAL CARE INFORMATION

By signing this form, I authorize you to release confidential health information about me by releasing a copy of my medical records, or a summary of narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name:_____ Date of Birth: _____

The information you may release subject to this signed release form is as follows:

_____ Progress Notes _____ History & Physical _____ Labs

_____ Medication _____ Procedure _____ Care Plan

_____ Communicable disease (including HIV & AIDS ___X_ All Records

Release my protected health information to the following Physician/facility/entity and/or those directly associated in my medical care:

Name: **Gastro Star**

Address:**3303 Rogers Rd Suite 250**

City, State: Zip Code: **San Antonio, TX 78251**

Phone: **210-405-3410**

Fax: **210-405-3411**

For the purpose of: CONTINUITY OF CARE

_____ _____

Patient Signature Date