Jose M. Sanchez MD
GASTROENTEROLOGIST

Michelle Formoso ARNP-C
Jessica Moreda-Cardenas, ACNP-BC
7000 SW 97 Ave. ,suit108 , MI , FL , 33173

Patient Information

Name: _____ Date of birth: _____ Age: _____ Sex: ___ M ____ F

Marital Status _____ Email: _____

Home Tel #: _____Cell #:_____

Home address: _____ City: _____State: ___ Zip Code: _____

Pharmacy phone number: _____

Name of Primary Doctor: _____ Phone#: _____ Fax#:_____

Informed Consent for Text (SMS) Messaging:

Jose M. Sanchez MD PA would like to send text (SMS) messages to the mobile number you have provided in our records. By providing your informed consent where indicated, you acknowledge that you have understood the information below and agree to participate in our text (SMS) messaging service. (Initial) Yes____ No____

Emergency Contact

Name: _____ Relation to Patient: _____

Phone#: _____

Assignment and Release of Records

I authorize payment of medical benefits to the physician(s) mentioned above for services rendered. In addition, I authorize the release of any medical or other information necessary to process my insurance claims.

Patient or authorized person's signature: Date:

_____ _____