Bach & Godofsky
Infectious Diseases

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

PATIENT INFORMATION

Name:		**Address:**
Date of Birth:	Marital Status: S M D W	Social Security Number:
Home Phone (____)_____-_____	Mobile Phone(____)_____-_____	Work Number(____)_____-_____

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

- **I agree to receive automated phone calls from Bach & Godofsky on my mobile phone about appointments, test results, or any other information. ☐Yes ☐No**
- **I agree to receive automated text alerts from Bach & Godofsky regarding appointments, test results, or any other information. ☐Yes ☐No**

Email for Portal Contact_____ **☐ NO ACTIVE EMAIL**

EMERGENCY CONTACT/RELEASE OF MEDICAL INFORMATION

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

I authorize the practice of Bach & Godofsky to speak with the CONTACTS listed above regarding my Private Healthcare Information (PHI). ☐Yes ☐No

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: (Please note that the physicians listed below will be provided with a visit summary and access to your medical record)

Primary Care Physician _____ Phone(____)_____-_____

Referring Physician _____ Phone(____)_____-_____

Other physicians that you see:

_____

Check the boxes as authorization and sign/date below.

☐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.

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