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GASTROENTEROLOGY
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PATIENT INFORMATION SHEET

Thank you for choosing our practice! Please provide your most current personal information for quality and prompt services. Your information is to be used strictly for the purposes of communication and health insurance claim purposes.

PLEASE PRINT CLEARLY

PATIENT FIRST NAME:_______________________________ LAST NAME:_______________________________

HOME ADDRESS: ____

CITY:____ STATE: _______________ ZIP CODE:__________________

DATE OF BIRTH:_______________ (dd/mm/yyyy) SEX: Male / Female SOCIAL SECURITY:__________________

HOME TEL NUMBER:____________________________ WORK PHONE NUMBER:_____________________________

CELL PHONE:____________________________________ DATE TIME CONTACT NUMBER:___________________

EMAIL ADDRESS:_________________________________ EMERGENCY CONTACT:____________________________
TEL:________________________

Do you have a living will: __________ if yes, please provide the name of power of attorney: ______________________
Any DNR (Do Not Resuscitate) order:____________________

PATIENT OR PARENT / GUARDIAN'S EMLOYER:____

IF PATIENT IS A STUDENT, NAME OF SCHOOL / COLLEGE ____

City ___________________________________ State___________________________ Zip____________________

PREFERRED PHARMACY FOR PRESCRIPTION: NAME:____

LOCATION OF PHARMACY:____________________________ (STREET) ______________________________ (CITY)

PHAMRMACY TEL:_______________________ Body weight:_____________ lb , Height ______ feet _______inches

REFFERING PHYSICIAN:_______________________________________ TEL:_____________________________

CARDIOLOGIST:____ TEL:_____________________________

Optional information:
1. How did you find us? ( ) Referring physician ( ) internet ( ) Friends & family ( ) Phone directory, ( ) Other _________________
2. Are you suffering from hemorrhoids? ________________ What is the problems? Circle all that apply. Anal pain, itchy, anal discomfort, bleeding.

( ) In case of medical emergency, if the patient is of school age 15+, it is all right to treat in my absence.

SIGNATURE:____________________________ DATE:______________________