

GASTROINTESTINAL ASSOCIATES, P.C.

PATIENT INFORMATION RECORD

BERGEIN F. OVERHOLT, MD, FACP, MACG
BARRY V. MAVES, MD, FACP
J. DAVID LEE, MD, FACP
STANLEY L. MILLER, MD, DIPLOMAT ABIM
STEVEN J. BINDRIM, MD, DIPLOMAT ABIM

R. KENT FARRIS, MD, FACP, FACG
SARKIS J. CHOBANIAN, MD, FACP, MACG
MEADE C. EDMUNDS, MD, FACP
MARIA B. NEWMAN, MD, DIPLOMAT ABIM

F. RAYMOND PORTER, MD, FACP
CHARLES M. O'CONNOR, MD, FACP
JOHN M. HAYDEK, MD, FACP, FACG, AGAF, FASGE
RAJ I. NARAYANI, MD, DIPLOMAT ABIM

Date _____

SS# _____

Name: Miss _____
Mrs _____
Ms _____ Last _____ First _____ MI _____
Mr _____

Address _____
Street _____ City _____ State _____ Zip _____

Telephone: Home _____ Employer _____
Work _____ Employer address _____
Cell (optional) _____

Male M S W D

Sex: Female Marital status: Date of birth _____ Age _____

Referred by: Doctor _____ Address _____
Friend _____ Health Fair _____ Other _____

Primary care doctor _____
Name _____ Address _____

Spouse's name _____ Spouse's employer _____

Spouse's date of birth _____

Emergency contact name _____ Phone _____

INSURANCE INFORMATION

Primary insured's name _____ Date of birth _____

Primary insurance company name _____

ID number _____ Group number _____

Secondary insured's name _____ Date of birth _____

Secondary insurance company name _____

ID number _____ Group number _____

Do you have a Living Will or Advance Directives for healthcare? _____

If yes, where is the document located? _____

Do you have Durable Power of Attorney for healthcare? _____

If yes, where is the document located? _____

Would you like information regarding a living will? _____

What is the best way to contact you between 8:00 a.m. and 5:00 p.m. Monday-Friday? _____

May we leave a message on your home or work answering machine? _____