

Gastroenterology Specialists of Oregon, P.C.

Patient's Name: _____ Today's Date: _____

Date of Birth: _____ Account Number: _____

MESSAGE APPROVAL:

- Is it okay to leave a message at your **home**? Yes No (circle one)
- Is it okay to leave a message at your **work**? Yes No (circle one)
- Is it okay to leave a message on your **mobile**? Yes No (circle one) _____

PHARMACY INFORMATION:

Preferred Pharmacy Name & Location: _____

ADVANCED DIRECTIVE INFORMATION: (Please Read Carefully & Select the Appropriate Box)

- NO**, I do not have an Advanced Directive
- YES**, I do have an Advanced Directive. *I DO NOT have a copy available for my chart.*
- YES**, I do have an Advance Directive. *COPY ATTACHED for my chart.*

EMERGENCY CONTACT INFORMATION: (Not Living With You)

Name: _____ Relationship: _____

Phone Number: _____ Alternate Phone Number: _____

RELEASE INFORMATION:

- YES, I DO** wish to have my medical or billing information released to the following person(s):

Spouse's Name: _____

Partner/Significant Others Name: _____

Relative's Name & Relationship to You: _____

- NO, I DO NOT** wish to have medical or billing information released to any person(s), including those, if any, listed above.

(please initial) _____

SIGNATURE: _____ DATE: _____