Northwest Gastroenterology, PLLC
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Bellingham, WA 98225

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2930 Squalicum Parkway, Suite #202
Bellingham, WA 98225

(360) 734-1420 * FAX (360) 734-8748

PATIENT INFORMATION

PATIENT'S NAME: *Mr. / Mrs. / Ms. / Dr.* _____

BIRTHDATE: _____/_____/_____ [ ] MALE [ ] FEMALE [ ] OTHER SOCIAL SECURITY NUMBER _____-_____-_____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

EMPLOYER: _____ POSITION: _____

PRIMARY CARE DOCTOR/PROVIDER: _____

MARITAL STATUS: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Other: _____

SPOUSE/PARTNER: _____ *HIS/HER BIRTHDATE* _____/_____/_____

EMERGENCY CONTACT: (Someone that does not reside with you)

Name of relative/friend: _____Phone: ( ) _____

Relationship: _____Cell Phone: ( ) _____

I AUTHORIZE THE PHYSICIAN OR A MEMBER OF THE CLINICAL SUPPORT STAFF TO CONTACT ME AND/OR LEAVE INFORMATION AS INDICATED BELOW.

(Unless given permission, this practice will not leave information on your home or cell message machine.)

Home Phone and answering machine: [ ] Yes [ ] No *Work Phone and voice mail: [ ] Yes [ ]No*

Cell Phone and voice mail: [ ] Yes [ ] No

E-mail: [ ] Yes [ ] No *If yes, e-mails address:* _____@_____

In addition, I hereby authorize you to contact me at any telephone number, including pager and cell phone numbers provided by me or otherwise obtained by you, using an automatic telephone dialing system.

PATIENT SIGNATURE: _____**DATE:** _____

This authorization is valid until _____. As the patient, you have the right to contact the office and change your authorization for release of information at any time. This change MUST be in writing.

For Staff Use Only gMed Confirmed: By: _____ Date: _____