ORGA
Oak Ridge Gastroenterology Associates
Physicians Plaza
988 Oak Ridge Turnpike, Suite 200
Oak Ridge, Tennessee 37830
865-483-4366

Date: _____

PATIENT INFORMATION

Name (Last, First, Middle):				SSN#	Birthdate	Age	Sex
Mailing Address				City, State, Zip			
Home Phone		Cell Phone		Email Address			
Marital Status	Student Status ☐Full-Time ☐Part-Time	Smoker? Yes or No	Veteran (Y/N)?	Ethnicity: Hispanic or Non-Hispanic	Primary Care Physician		
Referring Physician		Referring Physician Contact #	Other Medical Providers				
Race (**Circle Answer**): African American, Alaskan Native, Asian, French, German, Greek, Hawaiian, Hispanic, Indian, Multi-Racial, Native American Indian, Pacific Islander, White					Language		
Emergency Contact Name		Emergency Contact Phone #s Hm:		Cell:			
Employer Name and Address				Work Phone #			

How did you learn about our office? Please circle one. Billboard Ad Direct Mail Hospital Referral
Insurance Newspaper Ad Patient Referral Physician Referral Previous Patient
Internet Self-Referral Yellow Pages Other:

If patient is a minor, please fill out this portion

Parent or Guardian's Name:	Parent or Guardian's Phone #s Hm:	Wk:	Cell:

RESPONSIBLE PARTY INFORMATION (if different from above)

Name (Last, First Middle		SSN#	Birthdate	Sex
Address		City, State, Zip		
Home Phone	Cell Phone	Work Phone	Relationship to patient	

PRIMARY INSURANCE

Name of Insurance Company	Name of Insured	Address of Insured (if different than address above)	
Insured's Birthdate	Insured's SSN #	Insured's Insurance ID #	Relationship to patient

SECONDARY INSURANCE (if applicable)

Name of Insurance Company	Name of Insured	Address of Insured (if different than address above)	
Insured's Birthdate	Insured's SSN#	Insured's Insurance ID #	Relationship to patient

Workers Compensation

Are you here for workers compensation YES____ NO____ Date:

Accident

Auto ☐ Work ☐ Other ☐ Date of Accident:

Do you have any Advanced Directives? (e.g., Living will or Advanced Care Plan) Yes_____ No_____
Do you have a Power of Attorney? Yes_____ No_____
If yes to the above questions please make sure we have a copy for your medical record.

A member of Covenant HEALTH.

Oak Ridge Gastroenterology Associates/Medication List

Date:_____

Patient Name:_____DOB:_____

Referring MD:_____Prim. Care MD:_____

Pharmacy Name:_____Pharmacy #:_____

Allergies:

1. _____ 2._____

3. _____ 4. _____

5. _____ 6. _____

If you need more room, please list on back.

Current Medications: *Dosage:*

_____

_____

_____

_____

_____

_____

_____

_____

_____

If you need more room please list on back or attach a list