161 Marginal Way
Portland, ME 04101
(P) 207-773-7964
(F) 207-773-9073

Patient Communication Form

Patient's Legal Name: ______________________________ **Date of Birth:** ____________________
First MI Last

Mailing Address:

____
Street Address City State Zip Code

Phone Numbers: **Circle One** **Circle One**

(_____) ____________________ Okay to leave message? Yes / No **Extended Message? Yes / No
☐Home ☐Cell ☐Work

(_____) ____________________ Okay to leave message? Yes / No **Extended Message? Yes / No
☐Home ☐Cell ☐Work
**Extended messages may contain medical and/or prescription information.

E-mail Address:

____
By providing my email address, I understand I will be enrolled into Portland Gastroenterology Center's patient portal.
Check this box if you do NOT want to be enrolled in the patient portal. ☐

Primary Coverage
Insurance Company: __________________________ Subscriber ID: ________________ Group #: __________
Secondary Coverage
Insurance Company: __________________________ Subscriber ID: ________________ Group #: __________

Who is the patient's primary care physician? ____

Emergency Contact Name: ______________________________ **Relationship:** ____________________

Emergency Telephone: Cell (___) ___________ Home (___) _____________ Work (___) ______________

Select One:

☐ **I do <u>not</u> want any information about my healthcare communicated to family members/caregivers.**
☐ **I give Portland Gastroenterology Center permission to verbally communicate to family members/caregivers listed below:**
Full name and relationship: ____
Full name and relationship: ____

Please check the box(s) next to the specific information that may be **verbally** communicated to the individual(s) listed above:

☐ Protected Health Information (PHI) ☐ Prescription Request ☐ Request/Confirm/Cancel Appointments

I have the right to revoke this authorization in writing at any time. Revocation will not cover information released prior to that date. If I want to grant permission to Portland Gastroenterology Center to discuss including AIDS/HIV, Alcohol and/or Drug Abuse, or Mental Health with anyone besides myself, I understand that I will need to complete a separate Release of Information form.

____ ____________________
Patient/Parent/Legal Guardian Signature **Date**