GEORGE L. BARRETT, M.D.
CHIEF OF GASTROENTEROLOY
WWW.BOSTONDIGESTIVE.COM

Today's Date:	PCP:

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Home Phone:	Cell Phone:	Work Phone:	Birth date:	Age:	Sex: ☐ M ☐ F

Street address:	Primary Language:	Race/Ethnicity *(optional)*:

City:	State:	ZIP Code:	Email:

Occupation:	Employer:	Employer phone:

Referred to Dr. Barrett by:(Please check one.)	☐ PCP / Dr. ____________________	☐ Insurance plan	☐ Hospital
☐ Family	☐ Friend	☐ Online- *Please specify*	☐ Other

Pharmacy Name: ________________	Pharmacy Town/City: ________________	Pharmacy Phone: ______________________

INSURANCE INFORMATION

Please give your insurance card, license, and prescription card (if applicable), to the office staff upon check in.

Person responsible for bill:	Birth date:	Address (if different):	Home phone:

Is this person a patient here?	☐ Yes	☐ No

Please indicate primary insurance:	☐				

Subscriber's name:	Birth date:	Group no.:	Policy no.:	Co-payment:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone:	Cell phone:

The above information is true to the best of my knowledge. I authorize the release of medical information necessary to process medical benefits. I authorize payment of medical benefits for services by the office to be paid directly to George L. Barrett, MD, PC.

Patient/Guardian signature: ____

Date: ________________

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