PLEASE PRINT CLEARLY

Mid-State Gastroenterology

1115 B Dow Street
Murfreesboro, Tn. 37130

Patient Name	SSN	Date of Birth	Age	Gender ☐ Female ☐ Male

Mailing/Street Address	City, State, Zip Code

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Greek ☐ Hispanic ☐ Indian ☐ Multi-Racial ☐ Native Hawaiian or other Pacific Islander ☐ White	Ethnicity ☐ Hispanic ☐ Non-Hispanic

Marital Status ☐ Divorced ☐Married ☐ Single ☐Separated ☐Widowed	Primary Care Physician	Referring Physician

Home Phone Number ( )	Day Phone Number ( )	Cell Phone Number ( )	Email Address

Patient's Employer Name	Employer Address	City, State, Zip Code

Spouse or Parent's Name	Home Phone Number ( )	Street Address	City, State, Zip Code
Spouse or Parent's Employer	Business Phone Number ( )	Emergency Contact	Phone Number ( )

Pharmacy Name:	Pharmacy Address:	Pharmacy Phone #:

IMPORTANT! PLEASE READ CAREFULLY.
INSURANCE AUTHORIZATION AND ASSIGNMENT AND/OR MEDICAL RELEASE.

I hereby authorize Mid-State Gastroenterology to furnish any information or to obtain any information from any insurance carrier, physician, attorney, employer, hospital, other health care provider, or any affiliated entity concerning my medical history, illness and treatments. I hereby assign Mid-State Gastroenterology all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Date ______________________ Signature ____

Insured's Name	Insured Date of Birth	SS#

YOUR HEALTH IS IN YOUR HANDS WITH PATIENT PORTAL

Access Office Notes and Medical Records Securely and Quickly.

Send Refill Requests to your Providers

Message your Provider

Change and cancel appointments

App is available for Apple and Android Users

Free and secure, access puts your medical history, lab results, tests results and medication in the palm of your hand

SIGN UP TODAY!!!!!!

EMAIL ADDRESS: ____