



Dr. Thomas Eastman
Dr. John Hong
Board Certified Gastroenterologists

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Center For Medical Weight Loss Gastroenterologist Nurse Practitioner Physician Assistant

Patient Information

Patient Name: _____ **Sex:**

 M F

D.O.B. _____ **Race:** _____ **Ethnicity:**

Social Security #: _____ **Marital Status:**

Address:

City/State: _____ **Zip code:**

Home Phone: _____ **Cell phone:**

_____ **Email address:**

Order preference to Contact you? Please list below

- | | | | | |
|----------|---------|-----------|---------|---------|
| 1. _____ | Morning | Afternoon | Evening | Anytime |
| 2. _____ | Morning | Afternoon | Evening | Anytime |
| 3. _____ | Morning | Afternoon | Evening | Anytime |

Emergency Contact: _____ Phone: _____

Employer Name: _____ Phone: _____

Employer Address: _____ Zip: _____

Primary Care Physician: _____ Phone: _____

Primary Insurance Information

Insurance company: _____

Policy #: _____ Group #: _____

Policy holder: _____ Relation to policy holder _____

Secondary Insurance Information

Insurance company: _____

Policy #: _____ Group #: _____

Policy holder: _____ Relation to policy holder: _____

Patient Signature: _____ Date: _____

Staff use only

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