ASSOCIATES IN GASTROENTEROLOGY

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To Our Patients,

We thank you for choosing our practice for your gastrointestinal medical care. We are looking forward to providing to you the highest quality of care.

Our practice is compliant with all of the new national and Medicare guidelines including electronic medical record, electronic prescriptions and identity theft compliance. We have enclosed for you some forms to complete prior to your appointment time. Completing this paperwork prior to your visit will help us to better evaluate your needs and to attempt to serve you in a more timely fashion.

You will need to bring with you at the time of your appointment:

- Completed forms,
- Your insurance cards
- A photo ID
- All of your current medications

If you have questions regarding the completion of the forms please feel free to contact our office at the above address and number. Thank you for your cooperation.

Sincerely,

The Physicians and Staff
Associates in Gastroenterology

Associates in Gastroenterology
Patient Information Form

Patient Information

Last Name________________________________ First Name_________________________ M.I._____ M / F

Race: Caucasian ______ African-American _______ Other _______

Social Security Number_____________________________ Date of Birth________________________________

Address______________________________________ City_______________ State_______ Zip ___________

Home Phone____________________ Work Phone______________________ Cell Phone ________________

Employer Name and Address ____

E-mail Address____

Spouse Information

Last Name______________________________ First Name______________________________ M.I.________

Social Security Number_____________________________ Date of Birth________________________________

Home Phone____________________ Work Phone______________________ Cell Phone ________________

Employer Name and Address____

Complete the section below regarding person responsible for insurance coverage:

Primary Coverage: Insurance Name ____

Last Name ____________________First Name_______________________ M.I._____

Secondary Coverage: Insurance Name ____

Last Name____________________First Name______________________ M.I._____

Are you a full time student: Yes _______ No _______

Name of person to contact in the case of an emergency other than spouse:

Name____ Relationship_______________ Phone#____________________________

Do you have a pharmacy of choice? (List name and Location)____

How did you hear of our practice? [ ] Newspaper Article / Ad [ ] Family Member/ Friend

[ ] Physician __________________ [ ] Internet / Website/ Google

Name of your primary care physician: ____

I hereby authorize payment of medical benefits billed to my insurance to Associates in Gastroenterology, PLC. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance, if the Practice does not participate with my insurance. I understand that in the event of default in the payment of any amount due and if this account is placed in the hands of a collection agency or attorney for collection or legal action an additional charge equal to the cost of collection, including the collection agency and attorney fees and any court cost incurred.

I agree to pay all co-payments, coinsurance, and deductibles at the time the service is rendered.

I also hereby authorize Associates in Gastroenterology LLC to leave information or message regarding my care at my home phone number including voice mail or answering service devices.

____ ________________________

Signature of patient or guardian *date*

Please turn page over

Associates in Gastroenterology

[This form is required by the federal government]

CONSENT FOR RELEASE OF INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I, ________________________________ , hereby authorize **Associates in Gastroenterology, PLC** to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, **Associates in Gastroenterology, PLC** can refuse to treat me.

I have been informed that **Associates in Gastroenterology, PLC** has prepared a notice ("Notice") which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations. I have been given a copy of this notice

I understand that I may revoke this consent at any time by notifying **Associates in Gastroenterology, PLC**, in writing, but if I revoke my consent, such revocation will not affect any actions that **Associates in Gastroenterology, PLC** took before receiving my revocation.

I understand that **Associates in Gastroenterology, PLC** has reserved the right to change his/her privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that **Associates in Gastroenterology, PLC** restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that **Associates in Gastroenterology, PLC** does not have to agree to such restrictions, but that once such restrictions are agreed to, **Associates in Gastroenterology, PLC** must adhere to such restrictions.

________________________________ ____________

Signature of patient or patient's representative **Date**

(Form MUST be completed before signing.)

____

Printed name of patient or patient's representative

____

Relationship to the patient

Release of Medical and Billing Information

I, ______________________, authorize the physicians and staff of Associates in Gastroenterology, PLC to release information on file regarding my medical treatment and my medical billing account to the persons listed below:

Name ________________________________ Relationship ________________________

Name ________________________________ Relationship ________________________

Name ________________________________ Relationship ________________________

I understand that by signing this release that designated person(s) above will be able to speak to any member of the medical staff. Furthermore, I understand that these medical practices cannot be held liable for any information the above stated person(s) may obtain regarding my medical and billing information.

Signature of Patient / Guardian ________________________ Date ________________

Witness Signature ________________________ Date ________________

I, ______________________, do not authorize anyone to have access to my medical and billing information.

Signature of Patient / Guardian ________________________ Date ________________

Witness Signature ________________________ Date ________________

Associates in Gastroenterology Patient Health Information Form

Patient Name: **Date:** ________________

SS# …-..- __________ **Date of Birth** __________________ **Age** ________ **Ethnicity:** ______________________________
Referring Physician: ___________________________________ **Primary Care Physician:** ________________________________

Pharmacy: ____ **Pharmacy Location/ Phone#** ____________________________
(All new prescriptions and refill prescriptions will be submitted electronically to your designated pharmacy)

What is the reason you are here today?____

____

Have you had any of the following regarding this problem: (Circle all that apply)

Blood Test, CT Scan, MRI, Ultra-sound, X-ray, Medication: _____________________________

Other____

***Chief Complaint*: What are your current symptoms: (Check All That Apply)**

	Yes	No		Yes	No		Yes	No		Yes	No
Abdominal Pain			Weight Loss			Alterations of bowel habits			Night Sweats		
Heartburn			Loss of appetite			Black tarry stools			Cough		
Indigestion			Bloating/ Flatulence			Rectal bleeding			Food Intolerance		
Difficulty swallowing			Excessive Gas			Hoarseness			Fever		
Painful swallowing			Constipation			Sore throat					
Nausea / vomiting			Diarrhea			Fatigue					

***Your Past Medical History* (Check All That Apply)**

	Yes	No		Yes	No		Yes	No		Yes	No
Diverticulosis			Hepatitis			Anemia			Bleeding tendencies		
Irritable bowel/ spastic colon			Pancreatitis			Shortness of Breath			High Cholesterol		
Colonic or Gastric Polyps			Cirrhosis			Asthma			Hypothyroidism		
Colon Cancer			Liver disease			Emphysema			Diabetes		
Ulcerative Colitis			Breast Cancer			Positive TB skin test			Kidney Problem		
Other Colitis			Prostate Cancer			Coronary Artery Disease			Urinary Problem		
Ulcer Disease			Liver Cancer			Heart Attack			Anxiety/ Depres		
			Other Cancer Type____________			High Blood Pressure			Other________		

Your Past Surgical History: (Check All That Apply)

	Colonoscopy	Colon Resection	EGD	ERCP	Aneurysm Repair	Gallbladder	Gastric Bypass	Hysterectomy	Joint Replacement	Heart Valve Replacement	Heart Surgery	Spleen Removal	Trouble with anesthesia
Yes													
No													

Other Surgeries:____

FAMILY HISTORY (Check All that Apply

	Colon Cancer	Other Cancer	Colonic or Gastric Polyps	Crohns	Ulcerative Colitis	Hepatitis	Hiatal Hernia	Irritable Bowel	Pancreatic Disease	Liver Disease	Ulcers	Coronary Artery	Heart Attack	High Blood Pressure	Diabetes
Mother															
Father															
Brother															
Sister															
Son															
Daughter															
Maternal Grandparent															
Paternal Grandparent															

Medications: **(List All Prescription and Over the Counter Medications that you are currently taking)**

Name of Medication	Dosage	Directions
Do you take aspirin daily? Yes / No		

Are you allergic to:	Yes	No	Reaction
Penicillin			
Sulfa			
Antibiotic			
X-Ray Dye			
Sedatives			
Other			

Social History: (Check All That Apply)

Tobacco Use: None 1 pk/day ______ 1+pk/day______ Year Stopped____
Alcohol Use: None Social 1/day 2-3/day 4+day Year Stopped____
Caffeine Use: Coffee_____cups/day Tea_____/day Cola Drinks_____/day
Street Drugs: Never_____ In the past_____ Occasionally_____ Frequently_____

Patient Signature: ______________________________