



Date of Visit: _____

New Patient Update

Mr. Mrs. Ms.

Male Female

Name: _____

Address: _____

Last

First

Middle

Street

City

State

Zip

Social Security Number: _____ Date of Birth: _____ Age: _____

Ethnic Origin: Hispanic Non-Hispanic

Race: Black/African American American Indian/Alaska Native Asian Multi-Racial Caucasian
 Native Hawaiian/Pacific Islander Refuse/Unknown Other

Religious Preference: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-Mail Address: _____

Employer: _____ Occupation: _____

Employer's Address: _____

Street

City

State

Zip

Marital Status: _____ Spouse: _____

Spouse's Employer: _____

Street

City

State

Zip

In case of Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Referring Physician: _____ Is this a Worker's Comp Claim? _____

Address: _____

Street

City

State

Zip

Medical Insurance Information

Primary Care Company: _____ Telephone Number: _____

Policy Number: _____ Certificate Number: _____

Group Number: _____ Policy Holder: _____ Relationship to Policy Holder: _____

Policy Holder's Birthdate: _____ Policy Holder's Social Security Number: _____

Secondary Insurance Company: _____ Telephone Number: _____

Policy Number: _____ Certificate Number: _____

Group Number: _____ Policy Holder: _____ Relationship to Policy Holder: _____

Policy Holder's Birthdate: _____ Policy Holder's Social Security Number: _____

Responsible Party

Mr. Mrs. Ms.

Name: _____

Last

First

Middle

Address: _____

Street

City

State

Zip

Responsible Party/Guarantor's Signature: _____

Authorization: I have read and agree to the terms and conditions and I hereby authorize the release of any medical information necessary to process my health insurance claim and request payment of benefits of the provider of services. This also includes authorization for Medicare. I understand I am financially responsible to Consultants in Gastroenterology, P.C./The Endoscopy Center, Inc. for charges not covered or denied by insurance company. **I further agree in the event of my non-payment, to pay the cost of collection and/or court costs and reasonable fees should this require.**

Insured/Patient's Signature: _____

Acknowledgements

Receipt of Privacy Practice / Emergency Contact

I hereby acknowledge receipt of Digestive Health Specialists, LLC Notice of Privacy Practices and I give Digestive Health Specialists, LLC permission to disclose my protected health information to the individuals listed below:

****Who can we release medical information to (other than your doctor)? Please list name, phone number (including area code), and relationship**

**** Who would you like to list as an emergency contact? Please list, name, phone number (including area code), and relationship.**

Patient Portal Consent

I give Digestive Health Specialists permission to contact me at the email address that is listed on my patient information form, regarding test results or any other healthcare information.

I consent to the patient portal

I decline the patient portal

Photo Consent for Identification Purposes in the Patient Record

Please choose one option below:

I consent to have my Photo taken

I decline to have my Photo taken

Financial Responsibility

Authorizations: I have read and agree to the terms and conditions and hereby authorize the release of any medical information necessary to process my health insurance claim and request payment of benefits to the provider of services. This also includes authorization for Medicare. I understand I am financially responsible to Digestive Health Specialists, LLC / The Endoscopy Center Inc. for charges not covered or denied by my insurance company. I further agree in the event of my non-payment, to the cost of collection and /or court costs and reasonable fees should this be required.

The undersigned certifies that the patient has read and understands the information above and fully accepts all terms specified above.

Signature of Patient/Guardian _____ Date _____

These signatures will expire one year from date signed.



PATIENT: _____ REFERRING PHYSICIAN: _____ AGE: _____ DATE OF BIRTH: _____

PATIENT PROFILE (CHECK ONE)

Married Divorced Single Separated Widowed

OCCUPATION _____

HABITS: Tobacco Use: Y/N Amount per day: _____

Alcohol Use: Y/N Amount per day: _____

Caffeine Use: Y/N Amount per day: _____

History of Drug Use _____

Smoking status: never smoker former smoker

current every day smoker current some day smoker

Last Colonoscopy: _____ Last Pap Smear: _____

Last EGD: _____ Last Mammogram: _____

Last menstrual Period: _____

Medical History and Recent Symptoms

(Circle all that apply)

General

- Fever
Sweats
Weight Loss/Gain
Loss of Appetite
Fatigue

Eyes/Ears/Nose/Throat

- Blurring
Vision Loss
Nasal
Loss of Hearing
Bad Taste in Mouth
Sore Throat
Hoarseness
Sores in Mouth
Glaucoma

Cardiovascular

- Chest pain
High Blood Pressure
High Cholesterol
Stents
Pacemaker/Defibrillator
Heart diagnosis
Swelling in extremities
Blood clots
Heart Murmur
Heart attack

Respiratory

- COPD
Short of Breath
Asthma
Sleep apnea
C-Pap/Bi-Pap
Cough
Wheezing
Excessive Sputum

Gastrointestinal

- Nausea
Vomiting
Diarrhea
Constipation
Change in Bowel Habits
Blood in stool
Jaundice
Abdominal Pain
Barrett's Esophagus
C-Diff Colitis
H pylori
Polyps
Difficulty Swallowing
Diverticulosis
Diverticulitis
Hemorrhoids
Ulcers
Ulcerative Colitis
Crohn's
Microscopic Colitis
Heartburn
Get Full Quickly at Meals
Abdominal distention
Gas/Bloating
Pain with Bowel Movement
Belching
Irregular Bowel Habits
Incontinence of Stool
Vomiting Blood
Hernia
Hepatitis A/B/C
Food/Milk Intolerance
Celiac Sprue
Other _____

Reason for Today's visit: _____

Medical History and Symptoms cont.

Neurologic

- Stroke/TIA
Neuropathy
Seizures
Dizziness
Memory Loss
Tremors
Lack of Coordination
Restless Leg Syndrome

Psychiatric

- Bipolar
Depression
Anxiety
Suicidal Thoughts
Emotional Problems

Endocrine

- Diabetes
Last Blood Sugar _____
Cold Intolerance
Heat Intolerance
Thyroid Problems
Excessive Thirst
Lymph Node Swelling

Personal History of cancer

Skin

- Rash
Itching

Genitourinary

- Kidney/Bladder Infections
Kidney Stones
Incontinence
Enlarged Prostate

Hematologic

- Bruising
Bleeding
Anemia

Allergic Immunologic

- Persistent Infections
HIV Exposure
Seasonal Allergies

Musculoskeletal

- Arthritis
Osteoporosis
Osteopenia
TMJ
Fibromyalgia

FAMILY HISTORY CANCER

Relative _____ Cancer _____

GI Cancers: Colon Esophagus Liver Pancreas

GI Illnesses: Ulcers Colitis Crohn's Celiac Sprue

Polyps

Surgeries

(Circle all that apply)

- Appendix
Gall Bladder
Back/Spinal
Brain
Breast
Colon
Esophagus
Heart
Hemorrhoids
Cataracts
Hysterectomy

- C-Section
Hernia/Groin
Joint Replacement
Laparoscopy
Prostate
Stomach
Tonsils
Tubal Ligation
Weight Loss Surgery
Stents
Pacemaker
Other Surgeries

