

Dear _____

Thank you for choosing **Center for Digestive Health**. Our goal is to provide you with friendly, efficient service in a professional manner.

Your Appointment Information is noted below...*Please read carefully.*

DATE _____

AT THE _____ **OFFICE.**

Please arrive 15 minutes prior to your appointment mentioned below.

Your appointment time is _____ AM/PM

You will be seeing Dr. _____

1. Enclosed are the forms we need **completed, signed and returned on the day of your appointment.** You will not be able to see the doctor until paperwork is **completed**, because this is important information that the doctor and staff will need to go over with you. **Please do not mail back- please bring information with you.**
2. **NEW PATIENT FORMS** enclosed for you to **complete** and **sign**.
3. Please bring **ALL CURRENT Insurance Cards and Personal Identification** with you at appointment to be **copied** at time of check in.
4. Please bring **Current Medication bottles/information**.
5. If your insurance plan requires an **Authorization and/or Referral**, **Please bring your Authorization and/or Referral with you.** Please note *you will not be able to see the doctor without an authorization or referral if your insurance requires it.*
6. A copy of your **most recent medical records, lab results and/or x-rays is needed for the doctor to review.** This includes any records from a previous gastroenterologist or any other records pertaining to your problem. **Contact our Medical Records Coordinator at 407-896-1726.**
7. **When you arrive for your appointment, please sign in and our Front desk reps will assist you. **Please note it is ok for you to eat for your first appointment, there is no dietary restrictions.**

****If any of the items listed above are not available when you come for your appointment, we reserve the right to reschedule your appointment.**

****Cancellation Policy: Cancellations require 24hr notice.**

There will be a \$25 charge for non-emergency cancellations.

****If you have any questions or need assistance, please feel free to contact us at 407-896-1726 or 800-436-1726.**

We look forward to meeting you and providing you the best care you need.

CENTER FOR DIGESTIVE HEALTH/ENDOSCOPY

PLEASE PRINT

IT IS IMPORTANT THAT YOU PROVIDE US WITH COMPLETE, CURRENT INFORMATION. PLEASE PRESENT YOUR INSURANCE I.D. CARD(s) AND YOUR DRIVER'S LICENSE.

Today's Date _____ New Patient Former Patient Referring MD: _____ PH #: _____ Primary Care Physician#: _____

HMO PPO Group Other: _____

Patient's Name: _____ Birth Date: ____/____/____ Current Age: ____
(Per Insurance Card) FIRST MI LAST

Personal Status: M W S D SS#: _____ - _____ - _____ Sex: M F

Race: Caucasian African American Hispanic Asian Native American Other _____

Address: _____ City: _____ ST: _____ Zip: _____

Phone: Home () _____ Work: () _____

Cell Phone: () _____ During the hours of: _____

Employer: _____

Address: _____

How did you hear about us? _____

Notify in Emergency: _____

Relationship to you: _____

Phone #: () _____

INSURANCE INFORMATION

1ST Policy:

Carrier: _____ Policy#: _____

Address for Claims: _____ City: _____ ST: _____ Zip: _____

NAME OF POLICY HOLDER FOR THE ABOVE COVERAGE: _____ Birth Date: _____

Relationship to you: _____ S.S.#: _____ - _____ - _____

Name of Employer: _____

2ND Policy:

Carrier: _____ Policy#: _____

Address for Claims: _____ City: _____ ST: _____ Zip: _____

NAME OF POLICY HOLDER FOR THE ABOVE COVERAGE: _____ Birth Date: _____

Relationship to you: _____ S.S.#: _____ - _____ - _____

Name of Employer: _____

DOES YOUR INSURANCE COVERAGE REQUIRE PRE-AUTHORIZATION OR HAVE RESTRICTIONS FOR ORDERING LAB, X-RAYS OR HOSPITAL ADMISSIONS (INPATIENT OR OUTPATIENT)? YES NO

PLEASE TURN THIS PAGE OVER AND COMPLETE THE BACK-SIDE OF THIS FORM. THANK YOU!

**CENTER FOR DIGESTIVE HEALTH / ENDOSCOPY
FINANCIAL POLICY AND PATIENT RESPONSIBILITY STATEMENT:**

Payment for all services rendered by Center for Digestive Health/Endoscopy are due at the time of service unless other arrangements are made in advanced or we have a contract with your insurance plan.

Medicare Lifetime Signature on File:

I request that payment of authorized Medicare benefits be made on my behalf to Center for Digestive Health/Endoscopy for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services.

Patient, Parent or Guardian Signature (if child is under 18 years of age)

Date

Private Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned authorize payment of medical benefits to Center for Digestive Health/Endoscopy for any services furnished to me by the physician. I understand that I am financially responsible for any amount not covered by my contract, such as any deductible, co-payment, co-insurance, non-covered services, or services rendered if my insurance is terminated. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

Patient, Parent or Guardian Signature (if child is under 18 years of age)

Date

Patient's Rights and Responsibilities, HIPAA Privacy Practices, and Advanced Directives Acknowledgement of Receipt:

I, the undersigned acknowledge receipt of the document titled Patient's Rights and Responsibilities, HIPAA Privacy Practices, and Advanced Directives.

Patient, Parent or Guardian Signature (if child is under 18 years of age)

Date

MEDICAL RECORDS RELEASE:

I hereby grant permission to Center for Digestive Health/Endoscopy to release medical information to my insurance carrier(s) in response to their request for information required to file a claim for reimbursement on MY or PATIENT'S behalf.

SIGNED: _____ (PATIENT OR GUARDIAN)

DATE: _____

This is to authorize the verbal release of my medical condition, status, and/or test results, in the event that I am not home, to the following (specify all family members authorized):

Signature

Date

No expiration on authorization unless specified by patient



Patient: **Accuracy and completeness on this form is important to your health.**

Name _____

Age _____

Date: _____

List all current physicians (First & Last Name)

Primary _____

Specialists _____

Previous Gastroenterologists _____

Referred by _____

1. Present digestive or liver problem _____

1a. Previous Gastrointestinal Problems

(including esophagus, stomach, intestine large and small, liver, gallbladder and pancreas)

Type of problem	Date	Treatment
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____

2. Past medical history: Please check yes or no.

	Yes	No		Yes	No
Epilepsy/Seizures	_____	_____	Inflammatory Bowel Disease	_____	_____
Stroke	_____	_____	If yes, specify _____	_____	_____
Asthma	_____	_____	Diverticulitis	_____	_____
Shortness of breath	_____	_____	Kidney disease/stones	_____	_____
Sleep Apnea	_____	_____	Liver disease	_____	_____
Neck or back problems	_____	_____	If yes, specify _____	_____	_____
Hiatal Hernia	_____	_____	Jaundice	_____	_____
COPD/Emphysema	_____	_____	Cirrhosis	_____	_____
Lung disease	_____	_____	Hepatitis	_____	_____
If yes, specify _____	_____	_____	If yes, specify _____	_____	_____
High blood pressure	_____	_____	Anemia/Sickle Cell	_____	_____
Chest Pain	_____	_____	Bleeding/Blood disorders	_____	_____
Heart disease	_____	_____	If yes, specify _____	_____	_____
If yes, specify _____	_____	_____	Difficulty clotting	_____	_____
Artificial Heart Valve	_____	_____	Blood Transfusion	_____	_____
Heart Attack/MI	_____	_____	Cancer	_____	_____
Heart Murmur	_____	_____	Diabetes	_____	_____
Irregular Heart Beat	_____	_____	Thyroid Disease	_____	_____
Mitral Valve Prolapse	_____	_____	Arthritis	_____	_____
Pacemaker/Defibrillator	_____	_____	If yes, specify _____	_____	_____
Esophageal Reflux	_____	_____	Glaucoma	_____	_____
Heartburn	_____	_____	Infectious disease	_____	_____
Ulcer disease	_____	_____	If yes, specify _____	_____	_____
Nausea	_____	_____	TMJ	_____	_____
Vomiting	_____	_____	Hyperlipidemia	_____	_____

3. Family Medical History: Please enter the letter for the affected family member using the Chart below.

___ Hypertension	___ Ulcerative Colitis	___ Colon Cancer	Chart M-Mother F-Father B-Brother S-Sister C-Children G-Grandparent A/U-Aunt/Uncle
___ Diabetes	___ Crohn's Disease	___ Colon Polyps	
___ Heart Disease	___ Peptic Ulcer	___ Pancreatic Cancer	
___ Asthma	___ Gallbladder Disease	___ Hepatitis	
___ Emphysema	___ Pancreatitis	___ Stomach Cancer	
___ Cancer (Non G.I. Type)	___ Esophageal Cancer	___ Difficulty with anesthesia:	
List Cancer type _____		If yes, specify _____	
_____		___ Malignant Hyperthermia	

4. Social History

Married _____ Single _____ Divorced _____ Widowed _____

Your Occupation _____

Number of children _____

Spouse's Name _____

Spouse's Occupation _____

* Is there anyone else to whom may we release information? _____

4a. Diet: Please give an Example of your typical meal.

Typical Breakfast: _____

Typical Lunch: _____

Typical Dinner: _____

Dietary Restrictions _____

Are you able to use Milk and other Dairy Products: Yes ___ No ___

4b. Habits:

Smoke: Cigarettes _____ Number of packs per day _____ Pipe _____ Cigars _____

Alcohol: Number of drinks per day (including beer and wine) _____

5. Surgery: List all previous operations and dates:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Have you had any difficulty with anesthesia/sedation Yes ___ No ___ If yes, specify _____

(Example: History of Hyperthermia)

6. Allergies List all medicine allergies and type of reaction.

1. _____
2. _____
3. _____
4. _____

Are you sensitive to latex? Yes ___ No ___ If yes, specify _____

7. Medications: List all current medications (including over-the-counter medications).

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Have you used blood thinners or herbal supplements? Yes ___ No ___ If yes, specify _____

8. Women's Health:

Name of Gynecologist _____

Date of Last Menstrual Period _____ Any gynecological problems? If so, please explain: _____

Date of Last Pelvic Exam (PAP Smear) _____

9. Review of Systems: Please check any of the following problems which affect your current health.

Constitutional

Weight change in past six (6) months _____
Pounds gained _____ Pounds Lost _____
Change in appetite _____

Head/Nose

Headaches _____
Seizures _____
Sinusitis _____

Eyes

Double vision or loss of vision _____

Neck

Neck swelling _____

Respiratory

Shortness of breath _____
Chronic cough _____
Wheezing _____

Cardiovascular

Chest pain _____
Irregular heartbeats _____

Gastrointestinal

Nausea _____
Vomiting _____
Abdominal pain _____
Location of Pain _____
Constipation _____
Diarrhea _____
Change in frequency, size or color of stools _____
Rectal bleeding/Blood in Stool _____
Black Stool _____

Throat

Difficulty swallowing _____
Hoarseness/Throat Clearing _____

Genitourinary

Difficulty with urination _____
Change in Frequency _____

Musculoskeletal

Leg pain _____
Joint pain _____
Leg swelling _____

10. Is there anything else the doctor should be aware of? _____

Signature of Physician

Date