

PATIENT INFORMATION

PLEASE PRINT

Referring doctor _____ Family Doctor _____

Reason for visit _____

Last Name _____ First Name _____ (M.I.) _____

Address _____ City _____ State _____ Zip _____

Sex: M F Employer Name _____

Home Phone _____ Work Phone _____ Extension _____

Birthdate _____ Social Security _____

Marital Status: M S D W Spouse name _____

Guarantor Information (Person who holds insurance policy)

Name _____ Address _____

Social Security number _____ Birthdate _____

Employer name & phone _____

Patient Health History

Previous surgeries _____

Major medical problems/hospitalizations _____

Do you use Caffeine? Y N

Amount of the following per day: Coffee _____ Tea _____ Pop _____

Do you use tobacco? Y N Do you use alcohol? Y N

Current weight _____ Any changes in past year? _____

Check if you have ever had:

Diabetes Thyroid Disease Arthritis Anemia
 Cancer Heart problems Rectal bleeding

Illnesses that run in your family:

Cancer Diabetes Thyroid High blood pressure

Have you had recent x-rays? Y N What kind? _____ Where? _____

Have you had recent lab work? Y N When? _____ Where? _____

Which hospital do you prefer? _____

I hereby grant permission to the physicians and office staff to:

Yes No Call my home and leave a message on the answering machine.

Yes No May speak with whomever answers the phone. Information may include, but not limited to, test results, prescriptions, appointment, etc.

Yes No Call me at work.

Yes I do not want any information left on an answering machine or left with another person.

Who may we speak with regarding test results and anything else pertaining to your medical care: _____

Emergency Contact _____ Relationship _____ Phone _____

MEDICARE PATIENTS PLEASE SIGN BELOW

Statement to permit payment of Medicare benefit to provider, physicians, and patient

I request that payment of authorized Medicare benefits be made on my behalf to Michiana Gastroenterology, Inc. for any services furnished me by the listed provider. I authorize any holder of medical information to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. The physician agrees to accept the charge determination of the Medicare carrier as the full charge, and that I, as the patient or responsible party of the patient, am responsible only for the deductible, co-insurance and non-covered services. Co-insurance and deductible are based upon the charge determination of the Medicare carrier. A copy of this signature shall be as valid as the original.

X _____

Date _____

Signature of patient or patient's representative

ALL PATIENTS READ AND SIGN BELOW

Consent for release of information for the treatment, payment and health care operations

I hereby authorize Michiana Gastroenterology, Inc. 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, the doctor can refuse to treat me.

I authorize the release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me, to Michiana Gastroenterology, Inc. I understand I am financially responsible for any balance not covered by my insurance carrier. I also agree that if Michiana Gastroenterology, Inc. employs an attorney to assist in the collection of any sums due from me for services rendered, that I will pay the reasonable fees of such attorney and all court costs and expenses related to the extent permitted by law. A copy of the signature shall be as valid as the original.

I understand that I may revoke this consent at any time by notifying Michiana gastroenterology, Inc. in writing, but if I revoke my consent, such revocation will not affect any actions that Michiana Gastroenterology, Inc. took before receiving my revocation. I understand that Michiana Gastroenterology, Inc. has reserved the right to change their privacy practices and that I can obtain such changed notice upon request.

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

X _____

Date _____

Signature of patient or patient's representative

If I should not comply with the medical program of care provided or recommended by my physician or designated alternate(s), I understand that I then relieve my physician, designated alternate(s), and associated medical staff of all responsibility for consequences resulting from my action.

X _____

Date _____

Signature of patient or patient's representative

Printed name of patient's representative and relationship _____