

## **PATIENT INFORMATION**

**PLEASE PRINT**

Referring doctor \_\_\_\_\_ Family Doctor \_\_\_\_\_

First Name \_\_\_\_\_ (M.I.) \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex:  M  F Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security \_\_\_\_\_

Marital Status:  M  S  W  D Spouse name \_\_\_\_\_

Current weight \_\_\_\_\_ Any changes in past year? \_\_\_\_\_

Employment Status

- Working  Unemployed  Retired  
 Homemaker  Disabled  Full-Time Student

Employer Name \_\_\_\_\_

Work Phone \_\_\_\_\_ Extension \_\_\_\_\_

### **Guarantor Information (Person who holds insurance policy)**

Name \_\_\_\_\_ Address \_\_\_\_\_

Social Security number \_\_\_\_\_ Birthdate \_\_\_\_\_

Employer name & phone \_\_\_\_\_

### **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 \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

### **How did you first hear of us?**

- Friend /relative/word-of-mouth  Phone book  
 Newspaper/magazine  Doctor referral  
 Internet/web site  TV/Radio  
 Health insurance directory

Have you had recent x-rays? Yes No      What kind? \_\_\_\_\_      Where? \_\_\_\_\_

Have you had recent lab work? Yes No      When? \_\_\_\_\_      Where? \_\_\_\_\_

Have you had a prior endoscopy? Yes No      When? \_\_\_\_\_      Where? \_\_\_\_\_

Have you had a prior colonoscopy? Yes No      When? \_\_\_\_\_      Where? \_\_\_\_\_

Which hospital do you prefer? \_\_\_\_\_

**Personal Health History**      Hx = History

- Active      Hx      Abdominal pain
  - Right upper Quadrant
  - Right Lower Quadrant
  - Left upper Quadrant
  - Left lower Quadrant
  - Midline
- Active      Hx      Anemia
- Active      Hx      Anxiety
- Active      Hx      Arthritis
- Active      Hx      Asthma
- Active      Hx      Black Stool
- Active      Hx      Blood Clots
- Active      Hx      Blood in stool
- Active      Hx      Colon Cancer
- Active      Hx      Colon Polyps
- Active      Hx      Constipation
- Active      Hx      Coronary Artery Disease
- Active      Hx      COPD
- Active      Hx      Diabetes
- Active      Hx      Diarrhea
- Active      Hx      Depression
- Active      Hx      Epilepsy
- Active      Hx      Fever
- Active      Hx      Food sticks when swallowed

- Active      Hx      Heartburn
- Active      Hx      Heart problems  
(list type) \_\_\_\_\_
- Active      Hx      Hepatitis
- Active      Hx      High Blood Pressure -Hypertension
- Active      Hx      High Cholesterol
- Active      Hx      HIV
- Active      Hx      Lung Cancer
- Active      Hx      Lupus
- Active      Hx      Lymphoma
- Active      Hx      Nausea
- Active      Hx      Osteoporosis
- Active      Hx      Pacemaker
- Active      Hx      Parkinson's Disease
- Active      Hx      Prostate Cancer
- Active      Hx      Rectal bleeding
- Active      Hx      Reflux
- Active      Hx      Renal Failure
- Active      Hx      Stomach Ulcer
- Active      Hx      Stroke
- Active      Hx      Thyroid Disease
- Active      Hx      Tuberculosis
- Active      Hx      Vomiting
- \_\_\_\_\_
- \_\_\_\_\_

Previous surgeries \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Major medical problems/hospitalizations \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Allergies**

- None
- Dairy
- Seafood
- Adhesive Tape
- Dogs
- Seasonal
- Cats
- Latex
- \_\_\_\_\_
- Contrast dye
- Metal
- \_\_\_\_\_

**Medication Allergies**

- Aspirin
- Codeine
- Sulfur
- Ampicillin
- Iodine
- \_\_\_\_\_
- Amoxicillin
- Penicillin
- \_\_\_\_\_

**Social History**

Smoking status Current every day smoker Current some day smoker Former smoker Never smoked  
 If current or Quit within 12 months: Cigarettes Cigars Pipe Smokeless  
 If current or Quit within 12 months, Smoking Cessation Counseling: No Yes Date \_\_\_\_\_

Language English Spanish Other \_\_\_\_\_

Race  
White American Indian / Alaskan Other  
African American Asian Hawaiian / Pacific Islander Decline Answer

Ethnicity Hispanic or Latino Not Hispanic or Latino

Do you use alcohol? Yes No Rarely Drinks \_\_\_\_ Per Day Week

Caffeine (coffee, tea, cola, other caffeinated drinks) Yes No Cups \_\_\_\_ Per Day Week

Recreational Drug Use Yes No

Exercise Yes No 1-2 times a week 3 or more times a week

**Family History**

- |  |                                 |                                 |                                  |                                 |                                      |                                  |
|--|---------------------------------|---------------------------------|----------------------------------|---------------------------------|--------------------------------------|----------------------------------|
| <input type="checkbox"/> Colon Cancer        | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Grandparent | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Colon Polyps        | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Grandparent | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Crohn's             | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Grandparent | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Grandparent | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Grandparent | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Grandparent | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Osteoporosis        | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Grandparent | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Grandparent | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Thyroid Disease     | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Grandparent | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Ulcerative Colitis  | <input type="checkbox"/> Father | <input type="checkbox"/> Mother | <input type="checkbox"/> Brother | <input type="checkbox"/> Sister | <input type="checkbox"/> Grandparent | <input type="checkbox"/> Unknown |

**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 \_\_\_\_\_