Gastroenterology Associates, N.A. P.C.
Patient Demographic & Insurance Information

Basic Patient Information

Patient's Social Security Number: ____________________ Date: ____________________

Name of Patient: ____
First Middle Last

Birth Date: ____________ Age: ________ Gender: ❑ F ❑ M

Mailing Address: ____________________ City: __________ State: _____ Zip: __________

Street Address: ____

City: ____________________ State: ____________ Zip: ____________

Home Phone: ( ) ____________ Cell Phone: ( ) ____________ Work Phone: ( ) ____________

Employer: ____

Billing Information/Responsible Party/Guarantor for Encounter

Responsible Party: ____
(If Different from Patient) First Middle Last

Mailing Address: ____________________ City: __________ State: _____ Zip: __________

Street Address: ____

City: ____________________ State: ____________ Zip: ____________

Birth Date: ____________ Responsible Party's SSN: ____________ Gender: ❑ F ❑ M

Home Phone: ( ) ____________ Cell Phone: ( ) ____________ Work Phone: ( ) ____________

Responsible Party's Employer: ____

Insurance Coverage - Primary

Please present your insurance card & driver's license to the front desk receptionist when returning this form.

Name of Insurance: ____

Policy Number: ____________________ Effective Date: ____________________

Group Number: ____

Co-pay Amount: ____

Patient's Relationship to Policyholder: ❑ Self ❑ Child ❑ Spouse ❑ Guardian ❑ Other

Name of Policyholder: ______________________________ Gender: ❑ F ❑ M
(If Different from Responsible Party) First Middle Last

Birth Date of Policyholder: ____________________ Phone: ( ) ____________
(If Different from Responsible Party)

Name of Policyholder's Employer: ____
(If Different from Responsible Party)

(PLEASE SEE OTHER SIDE)

Insurance Coverage - Secondary

Name of Insurance: ____________________

Policy Number: ____________________ Effective Date: ____________________

Group Number: ____________________

Co-pay Amount: ____________________

Patient's Relationship to Policyholder: ❑ Self ❑ Child ❑ Spouse ❑ Guardian ❑ Other

Name of Policyholder: ____________________ Gender: ❑ F ❑ M
(If Different from Responsible Party) First Middle Last

Birth Date of Policyholder: ____________________ Phone: ( ) ____________________
(If Different from Responsible Party)

Name of Policyholder's Employer: ____________________
(If Different from Responsible Party)

Additional Patient Information

Were you referred to our practice? ❑ Yes ❑ No

Referring Physician: ____________________ ❑ Friend

Primary Care Physician: ____________________

Financial Responsibility Agreement

I/We hereby authorize Gastroenterology Associates to furnish all information regarding my medical history, diagnosis and treatment of myself or my child (if applicable) to an insurance company regarding my claims for benefits. If, however, said insurer fails to meet this obligation in whole or in part, or if I am non-insured, I/We agree to be responsible for the fee and cost involved in the treatment of the above named patient. I/We authorize payment for medical benefits to Gastroenterology Associates and further understand that should my account have to be referred to an attorney for collection that I am responsible for all fees and costs incurred therein. I/We hereby authorize Gastroenterology Associates to act on my behalf in accessing hospital records when and if needed.

____________________ ____________________

Date Patient or Guardian Signature

GASTROENTEROLOGY ASSOCIATES, N.A., P.C.
PATIENT CONTACT INFORMATION SHEET

Patient Name: ______________________________

Social Security Number: ______________________________

Any physician, staff, employee or representative of Gastroenterology Associates, N.A., P.C. has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information with the following persons in order to facilitate and coordinate my care, treatment and payment:

Name	Relationship	Phone Number(s)

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke it by writing to Gastroenterology Associates, N.A., P.C. or by completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individuals it may be subject to redisclosure by the individual(s).

Patient Signature: ______________________________ Date: ______________

☐ Copy given to patient

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Gastroenterology
Associates, N.A. P.C.

Medical History Form

Name: ______________________________ **Date of Birth:** _______________ **Todays Date:** ________________

Referring physician: ____________________ **Family physician:** _______________

Have you ever been diagnosed with any of the following?

- ☐ Reflux
- ☐ Barrett's Esophagus
- ☐ Esophageal Stricture
- ☐ Stomach or Duodenal Ulcer
- ☐ Irritable Bowel (IBS)
- ☐ Diverticulosis/Diverticulitis
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Colon Polyps
- ☐ Colon Cancer
- ☐ Celiac Disease
- ☐ Abdominal Adhesions
- ☐ Cirrhosis
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Fatty Liver
- ☐ Anemia
- ☐ Hemochromatosis
- ☐ High Blood Pressure
- ☐ Valvular Heart Disease
- ☐ Coronary Artery Disease
- ☐ Heart Attack
- ☐ Irregular Heart Beat/Arrhythmia
- ☐ High Cholesterol or Triglycerides
- ☐ Fibromyalgia
- ☐ Tuberculosis (TB)
- ☐ Arthritis
- ☐ Asthma
- ☐ Chronic Lung Disease/Emphysema
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Kidney Disease
- ☐ Stroke/TIA
- ☐ Seizures
- ☐ Parkinson's
- ☐ HIV/AIDS
- ☐ Glaucoma
- ☐ Anxiety/Depression
- ☐ Sleep Apnea
- ☐ Other Cancer__________
- ☐ Radiation Treatment

Have you ever had any of the following operations or procedures?

- ☐ Appendectomy
- ☐ Gallbladder
- ☐ Hysterectomy
- ☐ Cardiac Surgery
- ☐ Hemorrhoids
- ☐ Weight Loss/ Gastric Bypass
- ☐ Stomach or Ulcer Surgery
- ☐ Colon Resection
- ☐ Fundoplication/ Reflux or Hiatal Hernia
- ☐ Small Bowel Resection
- ☐ Other: _______________ _________________

- ☐ EGD Date:_______________ Findings:__________________
- ☐ Colonoscopy Date:_______________ Findings:__________________
- ☐ ERCP Date:_______________ Findings:__________________

Social History

Family Life

- ☐ Single
- ☐ Married
- ☐ Widowed
- ☐ Separated
- ☐ Divorced

Alcohol Consumption

- ☐ I do not drink Alcohol
- ☐ I drink less than 3 drinks of alcohol weekly
- ☐ I drink 3 or more drinks of alcohol weekly
- ☐ I drink 2 or more drinks daily
- ☐ I have a history of alcohol abuse

Tobacco Use

- ☐ I do not use Tobacco
- ☐ I smoke Tobacco products

Family History

- ☐ Unknown or **Adopted**
- ☐ I have no Family History of Colon Cancer or Colon Polyps

- ☐ Colon Cancer Who: _____________________ Age Diagnosed: _____
- ☐ Colon Polyps Who: _____________________ Age Diagnosed: _____

- ☐ Esophageal Cancer
- ☐ Pancreatic Cancer
- ☐ Celiac Disease
- ☐ Ulcerative Colitis
- ☐ Stomach Cancer
- ☐ Crohn 's Disease
- ☐ Liver Cancer

Gastroenterology
Associates, N.A. P.C.

Medical History Form

Do you currently have any of the following symptoms?

Gastrointestinal

- ☐ Heartburn
- ☐ Trouble Swallowing
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal Pain
- ☐ Bloating
- ☐ Flatulence
- ☐ Diarrhea
- ☐ Constipation
- ☐ Painful Bowel Movement
- ☐ Blood in Stools
- ☐ Poor Appetite
- ☐ Jaundice

Constitutional

- ☐ Fatigue
- ☐ Fever
- ☐ Chills
- ☐ Headache
- ☐ Night Sweats
- ☐ Unexplained Weight Loss

Eyes

- ☐ Blindness
- ☐ Eye Pain
- ☐ Change in Vision

Skin

- ☐ Rash
- ☐ Color Change
- ☐ Itching

Ears, Nose and Throat

- ☐ Decreased Hearing
- ☐ Mouth Ulcers
- ☐ Sore Throat
- ☐ Hoarseness

Cardiovascular

- ☐ Chest Pain
- ☐ Heart Murmur
- ☐ Palpitations/Fluttering
- ☐ Fast/Slow Heartbeat

Respiratory

- ☐ Shortness of Breath
- ☐ Asthma/Wheezing
- ☐ Cough

Urinary

- ☐ Painful Urination
- ☐ Urinary Frequency
- ☐ Blood in Urine

Neurological

- ☐ Loss of Consciousness
- ☐ Seizures/Convulsions
- ☐ Nervousness/Anxiety
- ☐ Depression

Hematologic

- ☐ Swollen Glands
- ☐ Easy Bleeding/Bruising
- ☐ Thrombosis/Blood Clots

Musculoskeletal

- ☐ Joint Pain or Stiffness
- ☐ Muscular Pain or Stiffness
- ☐ Back Pain

Endocrine

- ☐ Cold Intolerance
- ☐ Heat Intolerance

Do you have any medical allergies?

- ☐ I have none
- ☐ **Medication Allergies:** ____________________

What Medicines are you currently taking? (Use the back of this page if necessary)

Name: ____________________ **Dose:** __________ **Frequency:** ____________________

Name: ____________________ **Dose:** __________ **Frequency:** ____________________

Name: ____________________ **Dose:** __________ **Frequency:** ____________________

Name: ____________________ **Dose:** __________ **Frequency:** ____________________

Name: ____________________ **Dose:** __________ **Frequency:** ____________________

Name: ____________________ **Dose:** __________ **Frequency:** ____________________

Name: ____________________ **Dose:** __________ **Frequency:** ____________________