Gastroenterology Associates-Demographics

Date: ________________ **Chart #:** ______________

Name: ____________________________________

Address: __________________________________

City: _____________________________________

State, Zip: _________________________________

Home Phone: _______________________________

Mobile Phone: ______________________________

County: ___________________________________

Preferred Contact Method: ____________________

Emergency Phone different from patients: ___________

____

Emergency Contact Name and Relationship: ________

____

<u>Patient Email</u>: _______________________________

Birth date/Age: ______________________________

Sex: ______________________________________

Marital Status: **(Married, Single, Divorced, Widow)**

Race: **African American, Asian, White, Native American, And Other**: _________________________

Ethnicity: **Hispanic, Non-Hispanic, Unknown**:

Preferred Language: ____________________________

SS#: ______________________________________

PCP: ______________________________________

Referring M.D: ________________________________

Do have a living will? **Yes / No**

****

Have you ever had a colonoscopy? **Yes / No**

When ___________Dr. ____________ Polyps_________

Do you have a personal or family history of malignant hyperthermia? **Yes / No**

Employer: ___________________________________

Employer Phone #: ____________________________

Spouses Name: _______________________________

Date of Birth: ________________________________

Spouses SS# (for insurance purposes):______________

Contact #:____________________________________

Primary Insurance: _____________________________

Insurance Phone#: _____________________________

Insurance ID #: ________________________________

Is insurance in your name? **Yes / No**

Relationship to subscriber and Name: _______________

____

Secondary insurance: ___________________________

Insurance phone #: _____________________________

Insurance ID #: ________________________________

Is insurance in your name? **Yes / No**

Relationship to subscriber and Name: _______________

____

Pharmacy and Phone #: __________________________

____

Occupation: __________________________________

Retired? **Yes /No** What from? ____________________

Education: ___________________________________

****

Height: _______________ Weight: ______________

Do you have an automatic implantable defibrillator? (Pacemaker)? **Yes / No**

Do you have difficulty walking? **Yes / No**

Are you currently having bowel problems? ___________

____

(Please complete the back page)

HIPAA Privacy Acknowledgement

1. May we call the telephone number you provided and leave a message on an answering machine or with a family member/friend regarding your appointment or test results? Yes____ No_____.
   If No, is there another number we may use to reach you?
   Area Code:______ Phone Number: ________________
   May we call you at work? Yes ______ No_____ Work Phone Number: __________________

2. May we mail information to your home address regarding your appointments or test results?
   Yes____ No ____
   If NO, is there another address to which we may send your information? Please provide that mailing address: ____

3. Please list a family member (s) with whom we may release your medical information if needed:
   Name **Area Code and Phone Number** **Relationship**
   ____
   ____
   ____
   Please note that we can only release your medical information to the person (s) listed above.

4. A copy of the Physician's Practice "Notice of Privacy Practices for Protected Health Information" is located in the front office lobby and a copy available upon request.

____________________ ____________________
Signature Date

INSURANCE INFORMATION

Patient and /or guarantor are responsible for charges incurred. You are responsible on the day of your visit for your co-pay and /or percentage, for which your insurance company is not liable. If we are unable to obtain payment within a reasonable amount of time form the patient and /or guarantor, we will place your account with a collection agency, which will leave you liable for additional expenses incurred if applicable.

I have read and understand the above statement of payment policy. I hereby request any benefits on my behalf be paid to the physicians. I also authorize the release of any information required in the course of my treatment to my insurance company as needed to issue benefits.

____________________ ____________________
Signature Date

I request that payment of authorized Medigap (Medicare Supplement) benefits be made on my behalf to the provider for services furnished me by that provider. I authorize any holder of medical or other information about me be released to my Medigap Insurer to determine these benefits payable for released services.

____________________ ____________________
Signature Date

MEDICARE "B" SIGNATURE AUTHORIZATION

I authorize any holder of medical or other information about me be released to the Social Security Administration and Centers for Medicare and Medicaid Services or it's intermediaries or carriers, or to the billing agent of this physician or supplier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the party who accepts assignment.

I understand that this is a lifetime authorization.

____________________ ____________________
Signature Date

Patient Interview Form

Patient Information

First Name: ______ Last Name: ______
MRN: ______ Date Of Birth: ______
Age: ______ Notes: ______

Email
Please check one as your preferred email for communications

- Personal: ______
- Work: ______

Race
Select one or more

- White
- Black or African American
- Asian
- American Indian or Alaska Native
- Native Hawaiian or Other Pacific Islander
- Unknown
- Patient declines to specify

Ethnicity

- Hispanic or Latino
- Not Hispanic or Latino
- Patient declines to specify

Sex

- Male
- Female
- Other

Preferred Language

- English
- Spanish; Castilian
- Patient declines to specify

Contact Preference

- Letter
- Primary Telephone Number: ______
- Email Address: ______
- Cell Phone Number: ______
- Work Number: ______
- Patient declines to specify

Allergies

- Patient has no known allergies
- Patient has no known drug allergies
- Aspirin
- Codeine
- Demerol
- Iodine
- Latex
- Morphine
- Novocain
- Penicillins
- Propofol
- Sulfa
- Surgical Tape
- Versed

Other: ______

Immunizations

- None
- Flu vaccine When:
- Hep B When:
- Hep A When:
- Pneumonia When:
- Shingles When:
- TB Skin Test When:
- Tetanus When:

Diagnostic Studies/Tests

- None
- Lab Work When:
- X-Rays When:
- Stool Studies When:
- Other:
- Other:

Past or Present Medical Conditions

- None

GI Related

- Anemia
- Chronic Constipation
- Cirrhosis of Liver
- Colitis
- Colon cancer
- Colon Polyps
- Crohn's Disease
- Diarrhea
- Diverticulitis
- Diverticulosis
- Duodenal Ulcer
- Fatty Liver
- Gallstones
- Hepatitis A
- Hepatitis B
- Hepatitis C
- Hiatal Hernia
- Irritable Bowel Syndrome
- Lactose Intolerance
- Pancreatitis
- Reflux
- Stomach Ulcer
- Ulcerative Colitis
- Other:

General

- Asthma
- Atrial Fibrilation
- Back Pain (chronic)
- Breast Cancer
- Cancer
- Chronic Lung Disease
- Congestive Heart Failure
- Depression
- Diabetes Mellitus
- Emphysema
- Frequent Urinary Tract Infection
- Glaucoma
- Gout
- Heart Attack
- Heart Murmur
- High Blood Pressure
- High Cholesterol
- High Triglycerides
- History of Suicide Attempts
- HIV/AIDS
- Irregular Heart Beat
- Kidney Disease
- Kidney Failure
- Kidney Stone
- Lupus
- Migraines
- Osteoarthritis
- Paralysis
- Parkinson's Disease
- Phlebitis
- Pneumonia
- Rheumatic Fever
- Rheumatoid Arthritis
- Seizures
- Skin Cancer
- Sleep Apnea
- Stroke
- TB (Tuberculosis)
- TB Skin Test Positive
- Uterine Cancer
- Other:

Previous Procedures

- None
- Appendectomy
- Breast
- Cardiac Surgery
- Colonoscopy
- C-Section
- EGD/Upper Endoscopy
- ERCP
- Gallbladder/ Cholecystectomy
- Heart Bypass Surgery
- Heart Stent
- Heart Valve Replacement
- Hemorrhoids
- Hernia Repair
- Hysterectomy Partial
- Hysterectomy Total
- Joint Surgery/ Replacement
- Kidney
- Obesity Surgery
- Prostate
- Stomach
- Thyroid
- Tonsils
- Transplant Surgery
- Tubal Ligation
- Vasectomy

Other: ____________ Other: ____________

Social History

Occupation: ____________ Number of Children: ____________

Marital Status

- Single
- Married
- Divorced
- Separated
- Widowed
- Civil Union
- Unknown
- Other

Alcohol

- None

Type	Quantity	Number	Frequency
Beer			Times / week
Wine			Times / week
Liquor			Times / week

Caffeine

- [ ] None

Intake: ______________________________

Tobacco

Smoking Status

- [ ] Current every day smoker
- [ ] Current some day smoker
- [ ] Former smoker
- [ ] Never smoker
- [ ] Smoker, current status unknown
- [ ] Light tobacco smoker
- [ ] Heavy tobacco smoker
- [ ] Unknown if ever smoked

Type	Started	Quit	Quantity	Frequency
Cigarettes				Packs / Day
Cigar				Times / week
Smokeless				Times / week

Drug Use

- [ ] None

Type	Quantity	Number	Frequency
Illicit Drugs			
Injection Drug Use			

Exercise

- [ ] None

Type	Quantity	Number	Frequency
Aerobics			
Bike			
Golf			
Jog			
Lift Weights			
Swim			
Walk			

Consent to Share Data

I consent to having my medical and demographic information shared with other health care entities.

- [ ] Yes
- [ ] No

Reminder Preference

I would like to receive preventive care and follow up care reminders.

- [ ] Yes
- [ ] No

Consent to Import Medication History

I consent to obtaining a history of my medications purchased at pharmacies.

- [ ] Yes
- [ ] No

Reviewed with

- [ ] Patient
- [ ] Parent
- [ ] Guardian
- [ ] Not Present

FAMILY MEDICAL HISTORY

Tell us about the illnesses that have occurred in your family. If any family members are dead, tell us what the cause of death was, if you know.

FAMILY	LIVING	DEAD	ILLNESSES (describe any that are present)	AGE @ DEATH
MOTHER				
FATHER				
SISTER				
" "				
" "				
" "				
BROTHER				
" "				
" "				
" "				
CHILDREN				
Son's				
" "				
" "				
" "				
Daughter's				
" "				
" "				
" "				

Check the box provided if anybody in your family has had the following diseases:

o COLON CANCER (How old was this person when colon cancer was found? ________yr.)

o COLON POLYPS o ULCERATIVE COLITIS o CROHN'S DISEASE

Who in your family had these problems?____

Medication List

Please complete the information below and return with the health history in the envelope provided.

Today's date: ______________________ Account Number: ________________

Name: ____ Date of birth: ____________________

Name, phone number, and location of preferred pharmacy: ______________________________________

____

Drug allergies: ____

List all current medications that you currently take, including vitamins, over the counter medications and herbal preparations.

Medication Name (Please Print Clearly)	Dosage	Frequency (How often per day)	Check if need refill

Gastroenterology Associates

235 Medical Park Blvd
Bristol, TN 37620

Medical Records Release

GA chart number: __________

Patient Name: ____
Last   First   MI   Maiden or other Name

Address: ____________________ City: __________________ State: ________ Zip: _______

Date of birth: __________________________ SS#: ______________________________

I authorize ______________________________ to release information from my medical records
Name of Provider
as indicated below:

Gastroenterology Associates
235 Medical Park Blvd
Bristol TN. 37620
Phone: 423-274-6350
Fax: 423-274-8449

Information to be released:	Dates:
☐ History and physical exams	__________________
☐ Progress notes	__________________
☐ Lab reports	__________________
☐ X-ray	__________________
☐ Colonoscopy with path report	__________________
☐ EGD with path report	__________________
☐ Other:_____________	__________________

I understand that I am being requested to release this information for the purpose of continuation of care and this authorization will expire 1 year after I have signed this form. I understand that in compliance with Tennessee statute there will be no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment.

Patient's Signature: ________________   Date: ____________________

NO SHOW/CANCELLATION/RESCHEDULE POLICY

We understand that scheduling conflicts occur from time to time however, we request at least 24 hours advance notice if you are unable to keep your scheduled appointment. There will be a $30.00 charge for missing a scheduled appointment, or for cancelling or rescheduling without a 24 hour notice. Two no-shows, cancellations, and/or reschedules may result in your dismissal from all Gastroenterology Associates providers.

This policy has been developed in an effort to better serve our patients by providing same day appointments for those who are sick and need to be seen. If someone schedules an appointment and then does not show, cancels, or reschedules we have lost an available appointment that could have been used for a sick patient.

Please sign below as confirmation that you have read, acknowledge and understand our policy regarding no shows, cancellations and reschedules.

Patient Signature____

Date____

Chart #: ____________

Effective 05/13/13

ECB

THE ENDOSCOPY CENTER
OF BRISTOL, LLC

NO SHOW/CANCELLATION/RESCHEDULE POLICY

We understand that scheduling conflicts occur from time to time however, we request at least 24 hours advance notice if you are unable to keep your scheduled appointment. There will be a $100.00 charge for missing a scheduled appointment or for cancelling or rescheduling without a 24 hour notice. Three no-shows, cancellations, and/or reschedules may result in your dismissal from all The Endoscopy Center of Bristol physicians.

This policy has been developed in an effort to better serve our patients by providing procedure appointments in a timely manner. If someone schedules an appointment and then does not show, cancels or reschedules we have lost an available appointment that could have been used for a sick patient.

Please sign below as confirmation that you have read, acknowledged and understand The Endoscopy Center of Bristol policy regarding no shows, cancellations and reschedules.

Patient Signature____

Date____

Chart #: ___________

Effective 05/13/2013