PATIENT DEMOGRAPHICS

Thank you for allowing Digestive Healthcare to participate in your healthcare needs.

Today's Date: _____ Birth date: _____ SS#: _____

Patient Name: _____ Sex: _____

Race: _____ Ethnicity: ☐ Hispanic ☐Non Hispanic

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: ( )_____ Work Phone: ( )_____ Cell Phone: ( )_____

E-mail Address: _____ Primary Insurance: _____

Ins. ID#: _____ Policy Holder: _____

Relationship to Policy Holder: _____ Policy Holder's Date of Birth: _____

Secondary Insurance: _____ ID #: _____

Policy Holder: _____ Relationship to Policy Holder: _____

Policy Holder's Date of Birth: _____ Employer: _____

Primary Care Physician: _____

Pharmacy Name/Street/Phone Number: _____

Emergency Contact: _____ Phone #: ( )_____ Relationship: _____

I authorize the physician in charge to administer medical care as is necessary. Digestive Healthcare, PA's policy of payment has been explained to me, and I agree to be responsible for all medical expenses incurred as a result of services provided by Digestive Healthcare, PA. Copayments, deductibles, and coinsurance are due at the time of service. My payment options are cash, check, or charge. I understand that if I arrive late for my appointment, I may be asked to reschedule.

I understand that Digestive Healthcare, PA will file all insurance claims on my behalf. I agree that I am ultimately responsible for all charges incurred at Digestive Healthcare, PA regardless of third party liability. I also authorize Digestive Healthcare, PA to release any information necessary to file my claim.

I authorize the release of any medical information in possession of Digestive Healthcare, PA to any consultants or medical personnel for the purpose of rendering treatment to myself or to continue my care.

I have been made aware of the Notice of Privacy Practices and Cancellation Policy for Digestive Healthcare, PA and have received a copy if requested.

Patient Signature: _____ Date: _____

Guardian Signature (if applicable): _____ Date: _____

Release of Medical Information

Digestive Healthcare

Patient's Name: _____ Date of Birth: _____

We must call on occasion to discuss confidential protected health information. Below is a list of potential ways for us to communicate this information. Please indicate how you would like us to get this information to you:

It's okay to call:

_____ Home phone number- Leave a message: ___ yes ___no
_____ Mobile/Cell number- Leave a message: ___ yes ___no
_____ Work phone number- Leave a message: ___ yes ___no
_____ Call only this number: _____ Leave a message: ___ yes ___no
_____ Do not contact me by phone.

I give permission to the individual(s) listed below to receive protected health information:

_____ Give information to employer
_____ Give information to school
_____ Spouse (provide name)
_____ Parent (provide name)
_____ Other (provide name)

This authorization can be revoked or modified by notifying us IN WRITING at any time.

Patient's Signature_____ Date_____

Digestive Healthcare

PATIENT INFORMATION

NAME _____ DOB _____ PROCEDURE DATE _____

EMERGENCY CONTACT _____ RELATIONSHIP _____ PHONE# _____

REFERRING MD _____ REASON FOR VISIT _____

MEDICATION HISTORY

ALLERGIES _____ ○ **NONE** *LATEX allergy Y /N*

PLEASE LIST ALL MEDICATIONS AND THEIR DOSAGES. (INCLUDE REASON FOR USE) ○ **NONE**

_____ _____ _____

_____ _____ _____

_____ _____ _____

DO YOU TAKE?

○ NONE ○ ASPIRIN ○ VITAMIN E ○ BC POWDER ○ COUMADIN ○ ALEVE ○ PLAVIX ○ MOTRIN ○ LOVENOX ○ IBUPROFEN ○ TICLID/AGRENOX

MEDICAL HISTORY

HEIGHT _____ WEIGHT _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? **NONE** ○

CARDIAC:	○ HIGH BLOOD PRESSURE	○ HIGH CHOLESTEROL	○ HEART VALVE DISEASE	○ ANGINA	○ IRREG HEART BEAT
	○ STENT	○ PACEMAKER	○ HEART ATTACK	○ HEART FAILURE	○ OTHER
PULMONARY:	○ ASTHMA	○ EMPHYSEMA	○ COPD	○ SLEEP APNEA	
GI:	○ ACID REFLUX	○ BARRETT'S ESOPHAGUS	○ COLITIS/CROHN'S	○ COLON POLYPS	○ COLOSTOMY
	○ ULCERS	○ DIVERTICULITIS	○ COLON CANCER/POLYPS	○ HEPATITIS	○ PANCREATITIS
GU:	○ BPH	○ URINARY INCONTINENCE	○ ABN MENSES	○ URINARY TRACT INFECTIONS	
RENAL / ENDO:	○ DIABETES	○ KIDNEY PROBLEMS	○ DIALYSIS	○ THYROID PROBLEMS	
NEUROMUSC:	○ STROKE /TIA	○ PARKINSON'S	○ MIGRAINES	○ SEIZURES	
PSYCHOLOGIC:	○ DEPRESSION	○ ANXIETY	○ BIPOLAR DISORDER	○ SCHIZOPHRENIA	
AUTOIM/MISC:	○ ANEMIA	○ LUPUS	○ HIV/AIDS	○ RHEUMATOID DISORDER	

CANCER: GI OTHER (Please List) _____ CHEMO Y/N RADIATION Y/N

OTHER ILLNESSES: _____

DO YOU TAKE ANTIBIOTICS PRIOR TO DENTAL / MEDICAL PROCEDURES? Y/N

ARE YOU CURRENTLY PREGNANT? _____ **ARE YOU CURRENTLY BREASTFEEDING?** _____

FAMILY HISTORY

○ **NONE** *INDICATE WHICH FAMILY MEMBER HAS HAD ANY OF THE FOLLOWING*

○ ESOPHAGEAL CANCER _____	○ LUNG DISEASE _____	○ OTHER _____
○ STOMACH CANCER _____	○ HEART DISEASE _____	○ LIVER DISEASE _____
○ COLON CANCER _____	○ GYN CANCER _____	○ IBD _____
○ DIABETES _____	○ PANCREATIC CANCER _____	○ CELIAC DISEASE _____

SURGICAL /ENDOSCOPY HISTORY

HAVE YOU EVER HAD A PROBLEM WITH ANESTHESIA? Y/N

○ **NONE**	○ COLONOSCOPY	○ UPPER ENDOSCOPY	○ CARDIAC SURGERY	○ HEART STENT
○ COLON SURGERY	○ GALLBLADDER	○ APPENDECTOMY	○ OBESITY SURGERY	○ VALVE REPLACEMENT
○ HYSTERECTOMY	○ JOINT SURGERY	○ VASCULAR SURGERY	○ BREAST BIOPSY /SURGERY	○ OTHER _____

SOCIAL HISTORY

PLEASE INDICATE ALL THAT APPLY TO YOU

STATUS	○ SINGLE	○ MARRIED	○ DIVORCED	○ WIDOWED			
TOBACCO USE	○ NEVER	○ FORMER	○ ACTIVE	○ 1	○ 2	○ 3	PACKS / DAY
ALCOHOL USE	○ NEVER	○ FORMER	○ ACTIVE	○ 2	○ 7	○ 14	DRINKS / WEEK

OCCUPATION _____

Digestive Healthcare

REVIEW OF SYSTEMS

Please check yes or no for each selection below based on current issues only.

		Yes	No		Yes	No		Yes	No
Constitutional:	Weight Loss			Fever			Fatigue		
Eyes:	Glaucoma			Vision Problem			Eye Pain		
ENT:	Runny Nose			Sinus Pressure			Mouth Sores		
	Tooth Disease			Sore Throat			Hoarseness		
Heart:	Chest Pain			Heart Racing			Ankle Swelling		
	Leg Pain Walking			Dizziness			Fainting Spells		
Lungs:	Shortness of Breath			Cough			Wheezing		
Endocrine:	Increased Thirst			Increased Urination			Loss of Hair		
GI:	Heartburn			Trouble Swallowing			Loss of Appetite		
	Nausea/Vomiting			Diarrhea			Change in Bowel Habit		
	Constipation			Black Stools			Blood in Stool		
	Jaundice			Abdominal Pain			Getting Full Quickly		
Skin:	Rash			Psoriasis			Sores		
Musculoskeletal:	Trouble Walking			Trouble Standing			Muscle Pains		
Immune:	Allergies			Frequent Infections			Swollen Glands		
Neurologic:	Memory Problems			Temporary Blindness			Speaking Problems		
	Headaches			Numbness/Tingling			Loss of Balance		
Hematologic:	Nose Bleeds			Easy Bruising			Blood Donation		
Genitourinary:	Pain with Urination			Problem Starting Urination			Blood in Urine		
Psychiatric:	Depressed/Anxious			Suicidal Thoughts			Hearing Voices		

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____