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

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_______________

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 ________________________________

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: ________________________