Patient Demographics

UNC REX HEALTHCARE | Digestive Healthcare

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/PhoneNumber:_____

Emergency Contact: _____Phone #: ( )_____ Relationship_____

Healthcare Decision Maker: If you were unable to make healthcare decisions, who would you want to make healthcare decisions on your behalf? Same as emergency contact? Yes__ No__(fill out next line)

Name: _____ Relationship:_____ Phone number:_____

Release of Medical Information

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Patient's Name: _____ Date of Birth:_____

We must call or mail a letter 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
_____ Call Mobile/Cell number- Leave a message: ___ yes ___no
_____ Call 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_____

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Name: _____ DOB: _____Referring Provider: _____

Reason for Visit: _____

Vitals Office use only: Height_____ Weight_____ Temp._____ Blood Pressure_____/_____ Pulse_____ Resp._____

Allergies/Contraindications
Please list any known medication allergies: _____
Latex allergy? Y/N
Please list any blood thinners you are currently taking:_____

Medical History — Please circle if you have or have had any of the following:

Acute Pancreatitis	Colon Cancer	Fatty Liver	Kidney Disease/Stones
Alcoholism	Colon Polyps	Fecal incontinence	Lactose intolerance
Anemia	COPD	Gastroparesis	Liver disease
Ascites	Constipation	GERD	Pacemaker/Defibrillator
Barrett's Esophagus	Coronary Artery Disease	GI Bleeding	Rectal Cancer
C. Difficile	Crohn's Disease	Hepatic Encephalopathy	Sleep Apnea
Cancer_____	Diverticulitis	Hepatitis A/B/C	Small Intestinal Bacterial Overgrowth
Celiac Disease	Eosinophilic Esophagitis	High Cholesterol/Hyperlipidemia	Stroke/Seizures
Cholelithiasis/Gallstones	Esophageal Cancer	Hypertension	Ulcerative Colitis
Cirrhosis	Esophageal Varices	Irritable Bowel Syndrome	Other_____

Surgical History — Please circle if you have had any of the following surgeries or procedures:

Appendectomy	EGD/Upper Endoscopy	Hysterectomy
Cardiac Surgery	EUS	Small Bowel Resection
Cholecystectomy/Gallbladder	Fundoplication	Weight Loss Surgery
Colonoscopy	Heart Stent	Other: _____
C-Section	Hemorrhoidectomy	_____

Family History o Adopted o None Please list who if anyone in your family has any of the following:

Cancer _____	Crohn's Disease_____	Pancreatic Cancer_____
Celiac Disease_____	Esophageal Cancer_____	Pancreatitis_____
Gallstones_____	Family history of Colon Polyps_____	Stomach Cancer_____
Cirrhosis_____	Irritable Bowel Syndrome_____	Ulcerative Colitis_____
Colorectal Cancer_____	Liver Cancer_____	Other_____

Social History — Please circle your response and indicate quantity:

Tobacco Use: Never Former Active Quantity per day_____

Alcohol Use: Never Former Active Quantity per day_____

Occupation: _____

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Patient Name: ____________________

Date of Birth: ____________________

Medication and Supplement List

Medication	Dosage	Frequency	Reason for Taking

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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		

Print Name: _____ Date: _____

Patient Signature: _____

Physician Signature: _____ Date: _____

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Appointment Cancellation Policy

Office Visit Cancellation Policy

Please be prepared to pay co-payments and deductibles (if applicable) at time of service. Your appointment will be rescheduled if you do not have your copay.

A $25 cancellation fee will be charged if you do not call to cancel appointments 24 business hours in advance.

Please bring all of your insurance cards and medications to every appointment.

Procedure Cancellation Policy (If Applicable)

Due to the inability of Rex Digestive Healthcare to schedule another patient if adequate notification is not given to cancel or reschedule a procedure, we reserve the right to charge a fee of $150.00. A missed procedure is defined as a failure to show for your scheduled procedure or a cancellation/reschedule within less than two (2) business days prior to the procedure time.

We request that you notify us as soon as you are aware of your inability to keep your appointment so that we may schedule another patient for that procedure time. When calling to reschedule or cancel a procedure, you can reach us at 919-791-2040, and one of our nurses will handle your request. Please leave a detailed message if our nurses are busy helping other patients, and we will return your call promptly.

It is important that any reschedule/cancellation notice be called to the above number at Rex Digestive Healthcare. Do not contact Raleigh Endoscopy Center or Rex Hospital as Rex Digestive Healthcare will notify them of any changes. Failure to contact Rex Digestive Healthcare could result in a late cancellation fee of $150.00.

It is our priority to offer quality care to our patients, and this policy will ensure that we can accommodate all patients' needs efficiently. Thank you for your assistance and for choosing Rex Digestive Healthcare for your medical needs.

_____ _____

Patient Printed Name | Date of Birth

_____ _____

Patient Signature | Today's Date