

PATIENT INFORMATION - Please Print

Last Name _____ First Name _____ MI _____ Date of Birth _____

Address _____
 Street City State Zip

Home Phone _____ Cell Phone/Pager _____ Work _____

Email Address: _____

Sex M F Marital Status Minor Single Married Long-Term Partner Divorced Widowed Separated

Social Security # _____ Driver's License # _____ State _____

Employer _____
 Street City State Zip

In case of an emergency, whom should we contact? _____ Phone # _____

Nearest Relative (*not living with you*) _____
 Name Address/Phone # Relationship

Who should we thank for referring you to our practice? _____

INSURANCE INFORMATION - A Copy of Your Insurance Card & Driver's License (Photo ID) is Required

Primary Insurance _____ Phone # _____

Policy Holder _____ Policy# _____ SS# _____ Date of Birth _____

Secondary Insurance _____ Phone # _____

Policy Holder _____ Policy# _____ SS# _____ Date of Birth _____

COMMUNICATION AUTHORIZATION - Please Complete

We are committed to providing private and efficient communication with you. Please indicate the preferred method(s) of contact, should we need to reach you by phone. Place a check (✓) in the appropriate box(es).

- | | | | | | |
|-----------------------------------|---|--|-------------------------------------|-------------------------------------|---|
| <input type="checkbox"/> Home | <input type="checkbox"/> message to return call | <input type="checkbox"/> detailed message (results, treatment) | <input type="checkbox"/> NO message | <input type="checkbox"/> voice mail | <input type="checkbox"/> with an individual |
| <input type="checkbox"/> Work | <input type="checkbox"/> message to return call | <input type="checkbox"/> detailed message (results, treatment) | <input type="checkbox"/> NO message | <input type="checkbox"/> voice mail | <input type="checkbox"/> with an individual |
| <input type="checkbox"/> Cellular | <input type="checkbox"/> message to return call | <input type="checkbox"/> detailed message (results, treatment) | <input type="checkbox"/> NO message | <input type="checkbox"/> voice mail | <input type="checkbox"/> with an individual |

In certain instances, it may be necessary to communicate with via email. YES email NO email

RELEASE OF INFORMATION POLICY - Please Read

I hereby authorize Gastroenterology Associates of Texas, PA to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and other health care operations. My protected health information may be released to the following individual(s).

Name _____ DOB _____ Relationship to patient _____

Name _____ DOB _____ Relationship to patient _____

If this information is not completely filled out, Gastroenterology Associates of Texas, PA will not release information to anyone listed above.

RELEASE OF INFORMATION POLICY - cont'd

Name _____ DOB _____ Relationship to patient _____

Name _____ DOB _____ Relationship to patient _____

I have been provided the “Notice of Privacy Policies” for Gastroenterology Associates of Texas, PA, which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and other health care operations. I understand that I have the right to review such “notice” prior to signing this consent.

I understand that I may revoke this consent at any time by notifying Gastroenterology Associates of Texas, PA, in writing, but if I revoke my consent, such revocation will not affect any actions that Gastroenterology Associates of Texas, PA took before receiving my revocation.

I understand that Gastroenterology Associates of Texas, PA has reserved the right to change its privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that Gastroenterology Associates of Texas, PA restrict how my individually identifiable health information is used and/or disclosed to carry out treatment, payment, or other health care operations. I understand that Gastroenterology Associates of Texas, PA does not have to agree to such restrictions, but that once such restrictions are agreed to, Gastroenterology Associates of Texas, PA must adhere to such restrictions.

FINANCIAL POLICY - Please Read

I acknowledge full financial responsibility for services rendered by Gastroenterology Associates of Texas, PA, and authorize transfer of all unpaid amounts to me, which includes, but is not limited to, CO-PAYS, DEDUCTIBLES, CO-INSURANCE, PRE-EXISTING CLAUSES, CONDITIONS, and TERMINATION OF COVERAGE.

I agree to pay all legal fees including attorney and court fees as well as collection costs in the event of default of payment of charges that are my financial responsibility.

I further authorize and request that all insurance payments be made directly to Gastroenterology Associates of Texas, PA.

ACKNOWLEDGMENT - Signature Required

- I acknowledge that I have received the “Notice of Privacy Policies” for Gastroenterology Associates of Texas, PA.
- I hereby authorize Gastroenterology Associates of Texas, PA to release any information requested by the above named Insurance Company or Companies or respective representatives for payment of all services rendered.
- I understand that I am financially responsible to the physician for any charges incurred by myself and/or my dependents.

I have read and understand the “Release of Information Policy” and the “Financial Policy” established by Gastroenterology Associates of Texas, PA. I further acknowledge that I accept the terms outlined in each of the policies.

I understand that while this consent is voluntary, if I refuse to sign this consent, Gastroenterology Associates of Texas, PA can refuse to treat me.

Signature of patient or patient’s representative

Date

Printed name of patient or patient’s representative

Representative’s Relationship to the patient

NEW PATIENT GASTROINTESTINAL HISTORY FORM

First Name _____ MI _____ Last _____ MR# _____
 SS# _____ Date of Birth _____ Male Female Marital Status _____
 Occupation _____ Referring Physician _____

CHIEF COMPLAINT & PRESENT ILLNESS

Today's Date _____ Reason for Visit _____

List All Symptoms _____

If Symptom(s) include Pain, Please Check All That Best Describe Your Pain

Aching Burning Continuous Cramping Deep Dull Gnawing Gradual Intermittent Mild Moderate Periodic
 Sharp Shifting Stabbing Sudden Superficial Other _____

Location(s) _____ If Experiencing Abdominal Pain (please specify location)

RT Upper RT Lower LT Upper LT Lower Middle Other _____

Date Symptom(s) Began _____ Frequency of Symptom(s) ___ x Per Day ___ x per Week
 ___ x Per Month ___ x per Year Constant Intermittent Occasional Rare Recurrent Other _____

Intensity of Symptoms Excruciating Improving Mild Moderate Severe Other _____

How did symptom(s) start _____

How did symptom(s) progress _____

What brings it on _____ What makes it worse _____

What Relieves It _____ Associated Symptom(s) _____

How often do you take antibiotics Never _____ times per year Other _____

Comments _____

MEDICATIONS

List All Medications You Are Currently Taking. Include ALL Medications Even Over-The-Counter Products.

Drug Name (Generic/Brand)	Strenght/Dossage	Frequency	Reason for Medication

ALLERGIES

List Your Allergies Including Any Medication That Caused an Allergic Reaction.

Drug Name (Generic/Brand)	Strenght/Dossage	Frequency	Reason for Medication

First Name _____ Middle _____ Last _____

REVIEW OF SYMPTOMS

Check only the ones you have NOW or have had RECENTLY. Check NONE when applicable.

GENERAL <input type="checkbox"/> Weakness <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Night Sweats <input type="checkbox"/> Fainting <input type="checkbox"/> None	SKIN <input type="checkbox"/> Color Changes <input type="checkbox"/> Nail Changes <input type="checkbox"/> Hair Changes <input type="checkbox"/> Moles <input type="checkbox"/> Rashes <input type="checkbox"/> Itching <input type="checkbox"/> Sores <input type="checkbox"/> Dryness <input type="checkbox"/> None	HEAD <input type="checkbox"/> Headache <input type="checkbox"/> Injuries <input type="checkbox"/> Bumps <input type="checkbox"/> None	EYES <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Glaucoma <input type="checkbox"/> Redness <input type="checkbox"/> Itching <input type="checkbox"/> Burning <input type="checkbox"/> Swelling <input type="checkbox"/> Pain <input type="checkbox"/> Dryness <input type="checkbox"/> Tearing <input type="checkbox"/> None	EARS <input type="checkbox"/> Hard of Hearing <input type="checkbox"/> Deafness <input type="checkbox"/> Ringing <input type="checkbox"/> Discharge <input type="checkbox"/> Earache <input type="checkbox"/> Itching <input type="checkbox"/> Loss of Balance <input type="checkbox"/> Dizziness <input type="checkbox"/> Room Spins <input type="checkbox"/> None
NOSE <input type="checkbox"/> Decreased Smell <input type="checkbox"/> Bleeding <input type="checkbox"/> Pain <input type="checkbox"/> Discharge <input type="checkbox"/> Obstruction <input type="checkbox"/> Post Nasal Drip <input type="checkbox"/> Deviated Septum <input type="checkbox"/> Runny Nose <input type="checkbox"/> Sinus Congestion <input type="checkbox"/> None	MOUTH <input type="checkbox"/> Bleeding Gums <input type="checkbox"/> Sores/Blisters <input type="checkbox"/> Dental Problems <input type="checkbox"/> Pain <input type="checkbox"/> Bad Breath <input type="checkbox"/> Loss of Taste <input type="checkbox"/> Dryness <input type="checkbox"/> Ulcers <input type="checkbox"/> Bad Taste <input type="checkbox"/> None	THROAT <input type="checkbox"/> Sore Throat <input type="checkbox"/> Bad Tonsils <input type="checkbox"/> Hoarseness <input type="checkbox"/> Pain <input type="checkbox"/> Hard to Swallow <input type="checkbox"/> Recurrent Infection <input type="checkbox"/> White Spots <input type="checkbox"/> None	NECK <input type="checkbox"/> Enlargement <input type="checkbox"/> Stiffness <input type="checkbox"/> Soreness <input type="checkbox"/> Pain <input type="checkbox"/> Lumps <input type="checkbox"/> Masses <input type="checkbox"/> None	BREASTS <input type="checkbox"/> Discharge <input type="checkbox"/> Nodules <input type="checkbox"/> Pain/Tenderness <input type="checkbox"/> Changes <input type="checkbox"/> Skin <input type="checkbox"/> Bloatness <input type="checkbox"/> Masses <input type="checkbox"/> Bleeding <input type="checkbox"/> None
LUNGS <input type="checkbox"/> Cough <input type="checkbox"/> Phlegm <input type="checkbox"/> Coughed Blood <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Pain in Lungs <input type="checkbox"/> Chest Congestions <input type="checkbox"/> Inhalant Exposure <input type="checkbox"/> None	HEART <input type="checkbox"/> Murmur <input type="checkbox"/> Palpitations <input type="checkbox"/> Rapid Heartbeat <input type="checkbox"/> Swollen Extremities <input type="checkbox"/> Cold Extremities <input type="checkbox"/> Tightness/Pressure <input type="checkbox"/> Chest Pains <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Blood Clots <input type="checkbox"/> Blue Extremities <input type="checkbox"/> None	BLOOD <input type="checkbox"/> Broken Blood Vessels <input type="checkbox"/> Anemia <input type="checkbox"/> Easy Bruising <input type="checkbox"/> Prolonged Bleeding <input type="checkbox"/> Swollen Nodes <input type="checkbox"/> Painful Nodes <input type="checkbox"/> Red Dots/Spots <input type="checkbox"/> None	GASTROINTESTINAL <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Bloating <input type="checkbox"/> Belching <input type="checkbox"/> Heartburn <input type="checkbox"/> Indigestion <input type="checkbox"/> Irregular Bowels <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> GERD <input type="checkbox"/> Rectal Pain <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Hernias <input type="checkbox"/> Poor Appetite <input type="checkbox"/> Food Intolerance <input type="checkbox"/> Bloody Stools <input type="checkbox"/> Black Tarry Stools <input type="checkbox"/> Excessive Appetite <input type="checkbox"/> Rectal Bleeding <input type="checkbox"/> Dysphagia <input type="checkbox"/> Change in Bowel Habits <input type="checkbox"/> None	
GENITOURINARY <input type="checkbox"/> Urgency <input type="checkbox"/> Incontinence <input type="checkbox"/> Straining <input type="checkbox"/> Flank Pain <input type="checkbox"/> Frequency <input type="checkbox"/> Stones <input type="checkbox"/> Burning <input type="checkbox"/> Bed Wetting <input type="checkbox"/> Bloody <input type="checkbox"/> Small Stream <input type="checkbox"/> Urethral Discharge <input type="checkbox"/> Dribbling, Urinary <input type="checkbox"/> Cloudy Urine	<input type="checkbox"/> Unusual Color <input type="checkbox"/> Urination at Night <input type="checkbox"/> Hesitancy <input type="checkbox"/> None	MUSCULOSKELETAL <input type="checkbox"/> Pain <input type="checkbox"/> Weakness <input type="checkbox"/> Cramps <input type="checkbox"/> Twitching <input type="checkbox"/> Joint Stiffness <input type="checkbox"/> Joint Pain <input type="checkbox"/> Joint Swelling <input type="checkbox"/> Joint Deformities <input type="checkbox"/> Injuries <input type="checkbox"/> Curvature of Spine <input type="checkbox"/> Back Pain <input type="checkbox"/> Hot Joint <input type="checkbox"/> None	NEUROLOGICAL <input type="checkbox"/> Seizures <input type="checkbox"/> Vertigo <input type="checkbox"/> Hand Trembling <input type="checkbox"/> Loss of Sensation <input type="checkbox"/> Incoordination <input type="checkbox"/> Loss of Facial Expression <input type="checkbox"/> Weak Grip <input type="checkbox"/> Paralysis <input type="checkbox"/> Slurred Speech <input type="checkbox"/> Tingling/Burning/Numbing <input type="checkbox"/> Loss of Memory <input type="checkbox"/> Lack of Concentration <input type="checkbox"/> Disorientation <input type="checkbox"/> Gait Shuffling <input type="checkbox"/> None	
PSYCHIATRIC <input type="checkbox"/> Hyperventilation <input type="checkbox"/> Insecurity <input type="checkbox"/> Depression <input type="checkbox"/> Insomnia <input type="checkbox"/> Irritability <input type="checkbox"/> Anxiousness/Stress <input type="checkbox"/> Indecisiveness <input type="checkbox"/> Timid/Shy/Bashful <input type="checkbox"/> Hallucinations <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Use	<input type="checkbox"/> Suicidal Thoughts <input type="checkbox"/> Worrying <input type="checkbox"/> Obsessiveness <input type="checkbox"/> Mania/Depression <input type="checkbox"/> Multiple Personalities <input type="checkbox"/> Sexual Difficulties <input type="checkbox"/> Numbness <input type="checkbox"/> Panic Attacks <input type="checkbox"/> Drug Abuse/Addiction <input type="checkbox"/> Compulsiveness <input type="checkbox"/> None	ENDOCRINE <input type="checkbox"/> Weight Loss <input type="checkbox"/> Weight Gain <input type="checkbox"/> Hoarseness <input type="checkbox"/> Heat Intolerance <input type="checkbox"/> Cold Intolerance <input type="checkbox"/> Breast Changes <input type="checkbox"/> Loss of Hair <input type="checkbox"/> Extreme Thirst <input type="checkbox"/> Voice Changes <input type="checkbox"/> Excessive Hair Growth <input type="checkbox"/> Hypoglycemia (low blood sugar) <input type="checkbox"/> Diabetes (high blood sugar) <input type="checkbox"/> None		

VITAL SIGNS (Clinical use only)

Height _____	Temperature _____		BP	Pulse	Extremity	Comment
Weight _____	Auricular _____	Sitting _____	_____	_____	_____	_____
Respiration _____	Oral _____	Standing _____	_____	_____	_____	_____
		Supine _____	_____	_____	_____	_____