Gastroenterology Associates of Texas, PA
17510 West Grand Parkway South, Suite 220, Sugar Land, Texas 77479
Office: 281.201.1338 • Fax: 281.201.1353 • www.GregoryShannonMD.com

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).

☐ Home	☐ message to return call	☐ detailed message (results, treatment)	☐ NO message	☐ voice mail	☐ with an individual
☐ Work	☐ message to return call	☐ detailed message (results, treatment)	☐ NO message	☐ voice mail	☐ with an individual
☐ Cellular	☐ message to return call	☐ detailed message (results, treatment)	☐ NO message	☐ voice mail	☐ 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.

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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 may 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

Gastroenterology Associates of Texas, PA

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

Gastroenterology Associates of Texas, PA

First Name _____ **Middle** _____ **Last** _____

REVIEW OF SYMPTOMS

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

GENERAL
- ☐ *Weakness*
- ☐ *Fatigue*
- ☐ *Fever*
- ☐ *Chills*
- ☐ *Night Sweats*
- ☐ *Fainting*
- ☐ *None*

SKIN
- ☐ *Color Changes*
- ☐ *Nail Changes*
- ☐ *Hair Changes*
- ☐ *Moles*
- ☐ *Rashes*
- ☐ *Itching*
- ☐ *Sores*
- ☐ *Dryness*
- ☐ *None*

HEAD
- ☐ *Headache*
- ☐ *Injuries*
- ☐ *Bumps*
- ☐ *None*

EYES
- ☐ *Blurred Vision*
- ☐ *Glaucoma*
- ☐ *Redness*
- ☐ *Itching*
- ☐ *Burning*
- ☐ *Swelling*
- ☐ *Pain*
- ☐ *Dryness*
- ☐ *Tearing*
- ☐ *None*

EARS
- ☐ *Hard of Hearing*
- ☐ *Deafness*
- ☐ *Ringing*
- ☐ *Discharge*
- ☐ *Earache*
- ☐ *Itching*
- ☐ *Loss of Balance*
- ☐ *Dizziness*
- ☐ *Room Spins*
- ☐ *None*

NOSE
- ☐ *Decreased Smell*
- ☐ *Bleeding*
- ☐ *Pain*
- ☐ *Discharge*
- ☐ *Obstruction*
- ☐ *Post Nasal Drip*
- ☐ *Deviated Septum*
- ☐ *Runny Nose*
- ☐ *Sinus Congestion*
- ☐ *None*

MOUTH
- ☐ *Bleeding Gums*
- ☐ *Sores/Blisters*
- ☐ *Dental Problems*
- ☐ *Pain*
- ☐ *Bad Breath*
- ☐ *Loss of Taste*
- ☐ *Dryness*
- ☐ *Ulcers*
- ☐ *Bad Taste*
- ☐ *None*

THROAT
- ☐ *Sore Throat*
- ☐ *Bad Tonsils*
- ☐ *Hoarseness*
- ☐ *Pain*
- ☐ *Hard to Swallow*
- ☐ *Recurrent Infection*
- ☐ *White Spots*
- ☐ *None*

NECK
- ☐ *Enlargement*
- ☐ *Stiffness*
- ☐ *Soreness*
- ☐ *Pain*
- ☐ *Lumps*
- ☐ *Masses*
- ☐ *None*

BREASTS
- ☐ *Discharge*
- ☐ *Nodules*
- ☐ *Pain/Tenderness*
- ☐ *Changes*
- ☐ *Skin*
- ☐ *Bloatness*
- ☐ *Masses*
- ☐ *Bleeding*
- ☐ *None*

LUNGS
- ☐ *Cough*
- ☐ *Phlegm*
- ☐ *Coughed Blood*
- ☐ *Shortness of Breath*
- ☐ *Wheezing*
- ☐ *Pain in Lungs*
- ☐ *Chest Congestions*
- ☐ *Inhalant Exposure*
- ☐ *None*

HEART
- ☐ *Murmur*
- ☐ *Palpitations*
- ☐ *Rapid Heartbeat*
- ☐ *Swollen Extremities*
- ☐ *Cold Extremities*
- ☐ *Tightness/Pressure*
- ☐ *Chest Pains*
- ☐ *Varicose Veins*
- ☐ *Blood Clots*
- ☐ *Blue Extremities*
- ☐ *None*

BLOOD
- ☐ *Broken Blood Vessels*
- ☐ *Anemia*
- ☐ *Easy Bruising*
- ☐ *Prolonged Bleeding*
- ☐ *Swollen Nodes*
- ☐ *Painful Nodes*
- ☐ *Red Dots/Spots*
- ☐ *None*

GASTROINTESTINAL
- ☐ *Abdominal Pain*
- ☐ *Nausea*
- ☐ *Vomiting*
- ☐ *Bloatedness*
- ☐ *Belching*
- ☐ *Heartburn*
- ☐ *Indigestion*
- ☐ *Irregular Bowels*
- ☐ *Constipation*
- ☐ *Diarrhea*
- ☐ *GERD*
- ☐ *Rectal Pain*
- ☐ *Gas*
- ☐ *Hemorrhoids*
- ☐ *Hernias*
- ☐ *Poor Appetite*
- ☐ *Food Intolerance*
- ☐ *Bloody Stools*
- ☐ *Black Tarry Stools*
- ☐ *Excessive Appetite*
- ☐ *Rectal Bleeding*
- ☐ *Dysphagia*
- ☐ *Change in Bowel Habits*
- ☐ *None*

GENITOURINARY
- ☐ *Urgency*
- ☐ *Incontinence*
- ☐ *Straining*
- ☐ *Flank Pain*
- ☐ *Frequency*
- ☐ *Stones*
- ☐ *Burning*
- ☐ *Bed Wetting*
- ☐ *Bloody*
- ☐ *Small Stream*
- ☐ *Urethral Discharge*
- ☐ *Dribbling, Urinary*
- ☐ *Cloudy Urine*
- ☐ *Unusual Color*
- ☐ *Urination at Night*
- ☐ *Hesitancy*
- ☐ *None*

MUSCULOSKELETAL
- ☐ *Pain*
- ☐ *Weakness*
- ☐ *Cramps*
- ☐ *Twitching*
- ☐ *Joint Stiffness*
- ☐ *Joint Pain*
- ☐ *Joint Swelling*
- ☐ *Joint Deformities*
- ☐ *Injuries*
- ☐ *Curvature of Spine*
- ☐ *Back Pain*
- ☐ *Hot Joint*
- ☐ *None*

NEUROLOGICAL
- ☐ *Seizures*
- ☐ *Vertigo*
- ☐ *Hand Trembling*
- ☐ *Loss of Sensation*
- ☐ *Incoordination*
- ☐ *Loss of Facial Expression*
- ☐ *Weak Grip*
- ☐ *Paralysis*
- ☐ *Slurred Speech*
- ☐ *Tingling/Burning/Numbing*
- ☐ *Loss of Memory*
- ☐ *Lack of Concentration*
- ☐ *Disorientation*
- ☐ *Gait Shuffling*
- ☐ *None*

PSYCHIATRIC
- ☐ *Hyperventilation*
- ☐ *Insecurity*
- ☐ *Depression*
- ☐ *Insomnia*
- ☐ *Irritability*
- ☐ *Anxiousness/Stress*
- ☐ *Indecisiveness*
- ☐ *Timid/Shy/Bashful*
- ☐ *Hallucinations*
- ☐ *Alcohol Abuse*
- ☐ *Drug Use*
- ☐ *Suicidal Thoughts*
- ☐ *Worrying*
- ☐ *Obsessiveness*
- ☐ *Mania/Depression*
- ☐ *Multiple Personalities*
- ☐ *Sexual Difficulties*
- ☐ *Numbness*
- ☐ *Panic Attacks*
- ☐ *Drug Abuse/Addiction*
- ☐ *Compulsiveness*
- ☐ *None*

ENDOCRINE
- ☐ *Weight Loss*
- ☐ *Weight Gain*
- ☐ *Hoarseness*
- ☐ *Heat Intolerance*
- ☐ *Cold Intolerance*
- ☐ *Breast Changes*
- ☐ *Loss of Hair*
- ☐ *Extreme Thirst*
- ☐ *Voice Changes*
- ☐ *Excessive Hair Growth*
- ☐ *Hypoglycemia (low blood sugar)*
- ☐ *Diabetes (high blood sugar)*
- ☐ *None*

VITAL SIGNS (*Clinical use only*)

Height _____ Temperature _____

Weight _____ Auricular _____

Respiration _____ Oral _____

	BP	Pulse	Extremity	Comment
Sitting	_____	_____	_____	_____
Standing	_____	_____	_____	_____
Supine	_____	_____	_____	_____