## PATIENT INFORMATION

| NAME (LAST, FIRST, MIDDLE) | SSN# | BIRTHDATE | SEX |
|---|---|---|---|
| | | | |

| ADDRESS | CITY, STATE & ZIP CODE | EMAIL: |
|---|---|---|
| | | |

| MAILING ADDRESS (IF DIFFERENT FROM ADDRESS) | CITY, STATE & ZIP CODE |
|---|---|
| | |

| HOME PHONE | CELL PHONE | OTHER PHONE |
|---|---|---|
| | | |

| EMPLOYER | EMPLOYER PHONE |
|---|---|
| | |

## RESPONSIBLE PARTY INFORMATION

| NAME (LAST, FIRST, MIDDLE) | SSN# | BIRTHDATE | SEX |
|---|---|---|---|
| | | | |

| ADDRESS | CITY, STATE & ZIP CODE |
|---|---|
| | |

## INSURANCE INFORMATION
**(IF YOU PROVIDED INSURANCE CARDS, PLEASE SKIP THIS SECTION)**

| PRIMARY INSURANCE | POLICY # | SUBSCRIBER NAME | RELATIONSHIP / DOB |
|---|---|---|---|
| | | | |
| **SECOND INSURANCE** | **POLICY #** | **SUBSCRIBER NAME** | **RELATIONSHIP / DOB** |
| | | | |
| **THIRD INSURANCE** | **POLICY #** | **SUBSCRIBER NAME** | **RELATIONSHIP / DOB** |
| | | | |

## EMERGENCY CONTACT INFORMATION

| CONTACT NAME | RELATIONSHIP | PRIMARY PHONE | SECOND PHONE |
|---|---|---|---|
| | | | |

**I certify that the information I have provided herein is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare) for the purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I acknowledge that interest or a fee, at the providers current rate, may be charged on all balances on your account to the provider that are past due.**

SIGNATURE OF INSURED OR AUTHORIZED PERSON, PATIENT OR PARENT (IF MINOR) DATE

**PATIENT NAME:** _____ **D.O.B.** _____

## CONSENT FOR EVALUATION

The undersigned hereby consents to whatever evaluation or treatment the assigned healthcare provider may deem necessary to the patient named. As a patient of Total Gastroenterology, P.A. you are required to sign all sections of this patient packet.

PATIENT, PARENT, LEGAL GUARDIAN OR AUTHORIZED REPRESENTATIVE DATE

## FINANCIAL POLICY
## RESPONSIBILITY & INSURANCE ASSIGNMENT (INCLUDING MEDICARE PATIENTS)

I hereby authorize my insurance benefits to be paid directly to Total Gastroenterology, P.A. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. As a courtesy to our patients, we will continue to bill all primary and secondary insurance companies as we have done in the past. Your Insurance company requires that we collect your co-payment and/or deductible at the time of service. Patients who are unable to make their co-payments and/or deductibles will not be seen and will need to reschedule their appointments. Please be prepared to pay all responsible portions of the visit at the time of service such as your co-pay and/or deductible amounts. We appreciate your co-operation concerning this matter. Per patients request, refunds will be refunded any overpayment once all claims on the account have been processed.

**MEDICARE PATIENTS ONLY**

I certify that the information given by me in applying for payment from Medicare under Title XVIII of the Social Security Act is correct. I authorize any holder of medical and other information about me to release to the Social Administration or its intermediaries or carriers any information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in place of the original. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

PATIENT, PARENT, LEGAL GUARDIAN OR AUTHORIZED REPRESENTATIVE DATE

## REFERRALS/AUTHORIZATIONS

If your insurance plan requires a referral from your primary care physician, it is your responsibility to obtain it prior to your appointment and to have it with you at the time of service. If you do not have your referral, you will be required to reschedule your appointment.

PATIENT, PARENT, LEGAL GUARDIAN OR AUTHORIZED REPRESENTATIVE DATE

**PATIENT NAME:** _____ **D.O.B.** _____

## CANCELLATION/MISSED APPOINTMENTS POLICY

Our goal is to provide quality medical care in a timely manner. In order to do so, we have had to implement an appointment/cancellation policy. This policy enables us to better utilize available appointments for our patients in need of medical care.

### Cancellation of an Appointment:

In order to be respectful of the medical needs of other patients, please be courteous and call our office promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call **at least 24 hours in advance during normal business hours (weekends are not included)**, and calling early in the day is appreciated. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

### Late Cancellations:

Late Cancellations will be considered as a **"no-show"**.

### No-Show Policy

A "no-show" is someone who misses an appointment without canceling it in an adequate time manner. "No-shows" inconvenience those individuals who need access to medical care in a timely manner. A failure to present at the time of a scheduled appointment will be recorded in the patient's chart as a "no-show". The first time there is a "no-show", there will be no charge to the patient. Any additional "no-show" will result in a fee of **$25.00 billed to the patient's account**. A "no-show" for a surgical procedure will result in a fee of **$100.00 billed to the patients account**.

PATIENT, PARENT, LEGAL GUARDIAN OR AUTHORIZED REPRESENTATIVE _____ DATE _____

## PRESCRIPTION POLICY

After receiving a prescription request from your pharmacy or from you, we will make every effort to complete the process within 48-72 hours. **PLEASE CALL AT LEAST 10 DAYS PRIOR TO RUNNING OUT.**

If you are here for an appointment, please advise the MA or MA assistant if you need refills.

PATIENT, PARENT, LEGAL GUARDIAN OR AUTHORIZED REPRESENTATIVE _____ DATE _____

**PATIENT NAME:** _____ **D.O.B.** _____

## AUTHORIZATION FOR USE AND/OR DISCLOSURE AND REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION FORM

Pertaining to the Health Insurance Portability and Accountability Act (HIPPA), below are our attempts to protect the patient's right to privacy. The undersigned hereby consents to the release of medical information to the following individual or organization below. In the event medical information is requested from another provider, facility or pharmacy and the name or facility is not listed below, I hereby consent to the release of medical information in relation to the requested information to such provider.

☐ **PATIENT PREFERRED NOT TO SIGN, DO NOT GIVE ANY INFORMATION TO ANYONE OTHER THAN THE PATIENT. _____ Patient Initials**

**Doctor:** _____ **Facility:** _____

**Phone:** _____ **Fax:** _____

**Family / Other:** _____ **Phone:** _____

**Family / Other:** _____ **Phone:** _____

**Family /Other:** _____ **Phone:** _____

_____ _____

PATIENT, PARENT, LEGAL GUARDIAN OR AUTHORIZED REPRESENTATIVE DATE

DATE:_____
PATIENT NAME: _____ DOB: _____
ADDRESS:_____ PHONE#: _____
REFERRING DOCTOR: _____
PREFERRED PHARMACY: _____
RACE:_____ LANGUAGE_____ MARITAL STATUS:_____

*****NEW PATIENTS PLEASE COMPLETE ALL QUESTIONS BELOW*****
*****EXISTING PATIENTS NEED ONLY UPDATE ANY CHANGES*****

**DO YOU....**

**DRINK ALCOHOL:** YES NO IF YES: # OF DRINKS_____

HOW OFTEN: RARELY SOCIALLY DAILY

**TATTOOS** : YES NO **(IF YES)** # OF TATTOOS_____

**BLOOD TRANSFUSIONS**: YES NO IF YES, WHEN_____

**SMOKE** : CURRENT: EVERYDAY/SOME DAYS PACKS PER DAY:_____
FORMER SMOKER OR NON-SMOKER

**ANY FAMILY HISTORY OF CANCER:**
**(MOTHER, FATHER, SIBLINGS, AND/OR GRANDPARENTS;**

| WHO | ALIVE / DECEASED | TYPE OF CANCER |
|---|---|---|
| | ALIVE / DECEASED | |
| | ALIVE / DECEASED | |
| | ALIVE / DECEASED | |

**CURRENT MEDICATIONS:**_____
_____
_____

**ALLERGIES:**_____

**PLEASE NOTE THAT IF YOU DO NOT SHOW UP FOR A SCHEDULED OFFICE APPOINTMENT, YOU WILL BE CHARGED A $25.00 "NO-SHOW" FEE. FOR A SURGICAL PROCEDURE APPOINTMENT, YOU BE CHARGED A $100 "NO-SHOW" FEE.**

**Patient Signature:** _____

---

**FOR OFFICE USE ONLY**

**WEIGHT:** _____ **HEIGHT:**_____ **BMI:** _____

**BLOOD PRESSURE:**_____ **PULSE:**_____

## Review of Systems Today's Date: _____

Patient Name:_____ Date of Birth:_____

Where do you currently reside? (Circle one) Independently In an Assisted Living Facility In a Nursing Home

**Gastrointestinal**

| | |
|---|---|
| Nausea | No Yes |
| Vomiting | No Yes |
| Heartburn | No Yes |
| Food sticking in throat | No Yes |
| Painful swallowing | No Yes |
| Vomiting blood | No Yes |
| Black stool | No Yes |
| Red blood in stool | No Yes |
| Abdominal pain | No Yes |
| Constipation | No Yes |
| Diarrhea | No Yes |
| Loss of appetite | No Yes |
| Early satiety (feeling full fast) | No Yes |
| Bloating | No Yes |

**HEENT**

| | |
|---|---|
| Sore throat | No Yes |
| Hoarseness | No Yes |

**Cardiovascular**

| | |
|---|---|
| Abnormal heart rhythm | No Yes |
| Chest pain | No Yes |
| Palpitations | No Yes |

**Respiratory**

| | |
|---|---|
| Cough | No Yes |
| Shortness of breath on exertion | No Yes |
| Shortness of breath at rest | No Yes |
| Wheezing | No Yes |

**Neurological**

| | |
|---|---|
| Seizures | No Yes |
| Headaches | No Yes |

**Dermatology**

| | |
|---|---|
| Rash | No Yes |

**Musculoskeletal**

| | |
|---|---|
| Joint pain | No Yes |
| Arthritis | No Yes |

**Psychiatric**

| | |
|---|---|
| Dementia | No Yes |
| Depression | No Yes |
| Anxiety | No Yes |

**Constitutional**

| | |
|---|---|
| Recent weight gain # of pounds _____ | No Yes |
| Recent weight loss # of pounds _____ | No Yes |
| Fever | No Yes |
| Fatigue | No Yes |

**Genitourinary**

| | |
|---|---|
| Frequent urination | No Yes |
| Kidney failure/dialysis | No Yes |
| Painful urination | No Yes |
| Date of last menstrual period _____ | |

**Are you taking any blood thinners (Coumadin, Warfarin, Plavix, Pletal, Pradaxa, etc.) NO__ YES__**

**Current Medication-Please list all prescription and over the counter medicines including doses**

| | |
|---|---|
| | |
| | |
| | |
| | |

**Medical History**

| | | | |
|---|---|---|---|
| Ascites (extra fluid in abdomen) | No Yes | High Blood Pressure | No Yes |
| Asthma | No Yes | Kidney Failure | No Yes |
| Bleeding Disorder | No Yes | Kidney Stones | No Yes |
| Cancer What type _____ | No Yes | Liver Disease | No Yes |
| Congestive Heart Failure (CHF) | No Yes | Migraine Headaches | No Yes |
| Coronary Artery Disease (CAD) | No Yes | Pancreatitis | No Yes |
| Depression | No Yes | Peripheral Vascular Disease | No Yes |
| Diabetes | No Yes | Rheumatic Fever | No Yes |
| Emphysema or COPD | No Yes | Seizures | No Yes |
| Endometriosis | No Yes | Sleep Apnea | No Yes |
| Gallstones | No Yes | Stomach Ulcer | No Yes |
| Heart Arrythmia (A. Fib/ SVT/ A.Flutter) | No Yes | Stroke/TIA | No Yes |
| Heart Attack | No Yes | Thyroid Disease | No Yes |
| Hepatitis | No Yes | Valvular Heart disease orEndocarditis | No Yes |

Patient Name:_____Date of Birth: ____/____/____

**Drug Allergies/Intolerance**

| | |
|---|---|
| | |
| | |
| | |

**Past Surgical History**

| | | | |
|---|---|---|---|
| **Abdominal Surgery** | No Yes | **Gallbladder Removal** | No Yes |
| What type_____ | | **Heart Valve Replacement** | No Yes |
| **Appendectomy** | No Yes | **Hemorrhoid Removal** | No Yes |
| **Cancer Surgery** | No Yes | **Hip, Shoulder, Knee replacement within 1 year** | No Yes |
| What type _____ | | | |
| Coronary Artery Bypass (CABG) | No Yes | Hysterectomy (TAH) | No Yes |
| **Coronary Stent** | No Yes | **Laparoscopy** | No Yes |
| **Cosmetic Surgery** | No Yes | **Pacemaker** | No Yes |
| What type _____ | | **Salpingoophorectomy (BSO)** | No Yes |
| **Defibrillator** | No Yes | (tube and ovary removal) | |
| If yes, we need a copy of the card | | **Tonsillectomy** | No Yes |
| | | **Vascular Bypass/grafts within 1 yr** | No Yes |

**Hospitalizations (non-surgical)**

_____

_____

**Authorization & Release**

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I authorize the healthcare staff to perform the necessary services I may need and release information to others if necessary for my care.

_____

**Signature of patient** **Date**