Gastroenterology Associates, PA
Phone (864) 232-7338

Thank you for choosing Gastroenterology Associates.

As a new patient to our practice, we would like to welcome you and thank you for entrusting us with your care. In preparation for your upcoming appointment, PLEASE BRING THE FOLLOWING ITEMS:

- All of your medications OR a list of all of your medications (including dosage). List all Over the Counter medicine, vitamins, herbals, etc.
- Complete and bring all three (3) of the enclosed forms and questionnaires. Please do NOT mail.
- Your insurance cards (and Medicare D drug card if it applies).
- A picture ID.
- If your insurance requires pre-authorization for your visit, please bring the pre-authorization form provided by your primary care physician.

Please arrive 15 minutes prior to your scheduled appointment time. If you need to cancel or reschedule please call our office at (864) 232-7338 at least 48 hours prior to your scheduled appointment.

We look forward to providing your medical care.

Sincerely,
The Physicians and Staff
of Gastroenterology Associates, PA

PATIENT INFORMATION SHEET

(Please Print)

Name _____
(Last) (First) (MI) (Nickname)

Date _____ SS# _____ Birth Date _____ Sex _____

Mailing Address _____
(Street or PO Box) (City) (State, Zip)

Billing Address _____
(*If Different than Above*) (Street or PO Box) (City) (State, Zip)

County _____ Marital Status _____ Preferred Language _____

Appointment reminders by: ☐ Text Message ☐ Cell Phone ☐ Home Phone ☐ Day Phone

Cell phone _____ Home phone _____

Day Phone _____ Email _____

Race _____ Ethnicity: ☐ Hispanic Origin ☐ Not of Hispanic Origin ☐ Decline to provide

Employer _____ Work phone _____

Emergency Contact _____
(Name) (Relationship) (Phone #)

Primary Care Doctor _____ Referring Doctor _____

Primary Insurance Coverage

Name of Ins Co _____ Type of Coverage: ☐ Group ☐ Cobra ☐ Private

Name of Subscriber _____ Subscriber SS# _____

Subscriber Date of Birth _____ Patient's relationship to Subscriber _____

Subscriber Employer _____ Phone _____ Retired: ☐ Yes ☐ No

Secondary Insurance Coverage

Name of Ins Co _____ Type of Coverage: ☐ Group ☐ Cobra ☐ Private

Name of Subscriber _____ Subscriber SS# _____

Subscriber Date of Birth _____ Patient's relationship to Subscriber _____

Subscriber Employer _____ Phone _____ Retired: ☐ Yes ☐ No

PATIENT MEDICAL QUESTIONNAIRE

Name: _____ DOB: _____ Apt Date: _____ Provider: _____

Reason for your visit: _____

Do you have ***persistent or recurring*** problems with any of the following? *(Please check ✓ problem areas)*

GI:	***General:***	***Neurological:***	***Skin/Breast:***	***Genitourinary:***
__Abdominal Pain	__Dizziness	__Stroke	__Itching	__Painful urination
__Constipation	__Fatigue	__Seizure	__Rash	__Frequent urination
__Diarrhea	__Fever	__Severe headache	__Masses/Lumps	__Trouble urinating
__Difficulty Swallowing	__Heat or __cold intolerance	***Cardiovascular:***	__Jaundice/yellow skin	***Musculoskeletal:***
__Hemorrhoids	__Weight Loss _____lb	__Chest pain	***ENT:***	__Joint pain
__Heartburn/Reflex	__Weight Gain _____lb	__Irregular heart beats	__Cough	__Muscle pain
__Nausea	***Hematologic:***	***Psychiatric:***	__Hard of hearing	***Respiratory:***
__Rectal Bleed	__Anemia	__Depression	__Hoarseness	__Sleep Apnea
__Vomiting	__Bleeding tendency	__Anxiety/panic attacks	__Vision changes	__Shortness of breath

Medical History (e.g. Blood Pressure, Diabetes, Thyroid)

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Previous Surgeries / Dates

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Gallbladder Surgery? ☐ No ☐ Yes *If Yes:* ☐ Laparoscopic (4 puncture sites) ☐ Open (Big incision) ☐ Stones ☐ Disease

Hysterectomy? ☐ No ☐ Yes *If Yes:* ☐ Abdominal ☐ Vaginal ☐ Right Ovary Removed ☐ Left Ovary Removed

Family History: (Check ✓ if a family member has one of the following conditions; specify member and age of diagnosis.

☐ Cirrhosis _____ ☐ Heart Disease _____ ☐ Cancer _____ Type(s) _____
☐ Ulcerative Colitis _____ ☐ Crohn's Disease _____ ☐ Colon Polyps _____ ☐ Colon Cancer _____

What is the health status of your:

Mother: _____ Father: _____

Siblings: _____ (If family member is deceased, list cause of death *if known*)

Do you need to take antibiotics prior to dental work or surgery? ☐ Yes ☐ No
If Yes, Reason: _____

Vaccinated for Hepatitis A?: ☐ Yes ☐ No Date_____ B:? ☐ Yes ☐ No Date_____

Do you have heart stents?: ☐ Yes ☐ No *If Yes*, Date Placed: _____

Do you have a pacemaker?: ☐ Yes ☐ No Do you have a defibrillator? ☐ Yes ☐ No

Do you have a history of blood transfusions? ☐ Yes ☐ No Tattoos?: ☐ Yes ☐ No Piercings?: ☐ Yes ☐ No

Have you had a mammogram? ☐ Yes ☐ No *If Yes*, Date: _____ Current Occupation/ Employer: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Number of children: _____

Tobacco Use?: ☐ Yes ____ packs/day ☐ No For ____ yrs ☐ Former use

Caffeine Use?: ☐ Yes ____ drinks/day ☐ No

Alcohol Use?: ☐ Yes ____ drinks/day ☐ No ____ drinks/wk

Drug Use?: ☐ Yes ☐ No

Please list all medications you are currently taking, including dose and times you take. Include over the counter medications on this list. Continue on back, if needed.

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Medication Allergies: _____

I. AUTHORIZATION FOR RELEASE OF INFORMATION

OPTION 1: ☐ Do not discuss any health or financial information with anyone **except** me. _____(initial)

OPTION 2: ☐ This form authorizes Gastroenterology Associates, PA to release protected information to the people listed below (e.g. spouse, parent, sibling).

Name / Relationship to patient	Phone	Financial/Billing Information	Medical Information	May Leave Voicemail
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐

☐ In the event that I am unavailable, I authorize personal medical information to be left on my voicemail

- I understand that I have the right to revoke this authorization, in writing, at any time, and that I have the right to inspect or copy the protected health information to be disclosed as described in the document by sending a written notification to Gastroenterology Associates, PA. I understand that a revocation is not effective in cases where the information has already been disclosed.
- I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned upon signing.

This information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

X _____
Signature of Patient (or parent/legal guardian/personal representative)

II. NOTICE OF PRIVACY PRACTICES

Gastroenterology Associates, PA has provided me a copy of their Notice of Privacy Practices for my review upon check in.

X _____
Signature of Patient (parent or legal guardian if minor)

III. STATEMENT OF FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF INSURANCE BENEFITS

I understand that I am financially responsible for all charges not paid by insurance. I authorize the release of information to my insurance company for insurance/medical purposes. I hereby authorize payment from my insurance company to Gastroenterology Associates, PA.

X _____ _____
Signature of Patient (or parent/legal guardian/personal representative) Date

_____ _____
Print Patient Name Patient Date of Birth