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 **24 hours prior** to your scheduled appointment to avoid a $25 late cancellation or missed appointment fee.

We look forward to providing your medical care.

Sincerely,

The Physicians and Staff
of Gastroenterology Associates, PA
PATIENT INFORMATION SHEET
(Please complete all fields below)

Name: ___________________________________________ (Last) (First) (Middle) (Nickname)

SS#: ____________________________ Birth Date: ____________________________ Sex: ____________________________

Billing Address: ____________________________________________ (Street or PO Box) (City) (State, Zip)

Secondary Address: (If Different than Above) (Street or PO Box) (City) (State, Zip)

County: ____________________________ Race: ____________________________ Preferred Language: ____________________________

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Specify

Marital Status: ____________________________

Primary Care Doctor: ____________________________ Referring Doctor: ____________________________

Employer: ____________________________

Emergency Contact: ____________________________________________ (Name) (Relationship) (Phone #)

Appointment reminders by: ☐ Phone Call ☐ Email ☐ Text (SMS)

Cell Phone: ____________________________ Home Phone: ____________________________

Day Phone: ____________________________ Email: ____________________________

Primary Insurance Coverage

Name of Ins Co: ____________________________ Member ID#: ____________________________

Name of Subscriber: ____________________________ Subscriber SS#: ____________________________

Subscriber DOB: ____________________________ Relationship to Subscriber: ____________________________

Subscriber Employer: ____________________________

Secondary Insurance Coverage

Name of Ins Co: ____________________________ Member ID#: ____________________________

Name of Subscriber: ____________________________ Subscriber SS#: ____________________________

Subscriber DOB: ____________________________ Relationship to Subscriber: ____________________________

Subscriber Employer: ____________________________
Patient Name: _______________________
Gastro Provider: ___________
Date of Birth: __ / __ / __ __ __ __

**Why are you here today?**

Please check any persistent or recurring symptoms you have:

<table>
<thead>
<tr>
<th>GI:</th>
<th>General:</th>
<th>Neurological:</th>
<th>Skin:</th>
<th>Genitourinary:</th>
<th>GI:</th>
<th>General:</th>
<th>Neurological:</th>
<th>Skin:</th>
<th>Genitourinary:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal pain</td>
<td>Dizziness</td>
<td>Confusion</td>
<td>Itching</td>
<td>Abdominal pain</td>
<td>Fatigue</td>
<td>Seizures</td>
<td>Rash</td>
<td>Abdominal pain</td>
<td>Fever</td>
</tr>
<tr>
<td>Constipation</td>
<td>Fatigue</td>
<td>Severe headache</td>
<td>Rash</td>
<td>Constipation</td>
<td>Fever</td>
<td>Cold intolerance</td>
<td>Trouble urinating</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diarrhea</td>
<td>Heat intolerance</td>
<td></td>
<td>Breast lumps</td>
<td>Diarrhea</td>
<td>Cold intolerance</td>
<td>Jaundice/yellow skin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty swallowing</td>
<td>Weight loss</td>
<td></td>
<td>Rectal bleeding</td>
<td>Difficulty swallowing</td>
<td>Weight gain</td>
<td>Vomiting</td>
<td>Rectal bleeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heartburn</td>
<td></td>
<td></td>
<td></td>
<td>Heartburn</td>
<td></td>
<td></td>
<td>Rectal bleeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reflux</td>
<td></td>
<td></td>
<td></td>
<td>Reflux</td>
<td></td>
<td></td>
<td>Rectal bleeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nausea</td>
<td></td>
<td></td>
<td></td>
<td>Nausea</td>
<td></td>
<td></td>
<td>Rectal bleeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rectal bleeding</td>
<td></td>
<td></td>
<td></td>
<td>Rectal bleeding</td>
<td></td>
<td></td>
<td>Rectal bleeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vomiting</td>
<td></td>
<td></td>
<td></td>
<td>Vomiting</td>
<td></td>
<td></td>
<td>Rectal bleeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
<td>Other:</td>
<td></td>
<td></td>
<td>Rectal bleeding</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Hematologic:**

- Anemia
- Bleeding tendency

**Psychiatric:**

- Depression
- Anxiety
- Panic attacks

**Surgical History/Medical History:** (Check/write any that you have a history of. Continue on back if needed)

- High blood pressure
- Diabetes
- Coronary Artery Disease
- COPD
- Seizures

**Surgical History/Medical History:**

- Sleep Apnea
- Kidney disease
- Colon polyps
- Gallbladder Surgery
- Colon Surgery

**Family Medical History:** (Please list any chronic illnesses, causes of death, etc.)

- Colon Cancer:
- Stomach Cancer:
- Cancer (and type):
- Other:

- Ulcerative colitis:
- Crohn's disease:
- Colon polyps:
- Other:

**Allergies:** ________________________  ________________________  ________________________

Please list all medications and dosages, including supplements and OTC drugs. Continue on back if needed

____________________  ________________________  ________________________
____________________  ________________________  ________________________
____________________  ________________________  ________________________
____________________  ________________________  ________________________
I. AUTHORIZATION FOR RELEASE OF INFORMATION

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

OR

OPTION 2: ☐ This form authorizes Gastroenterology Associates, PA to release protected information to the people listed below (e.g. spouse, parent, sibling). Please check all boxes that apply to each individual listed.

<table>
<thead>
<tr>
<th>Name / Relationship to patient</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

☐ 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

Revised 8/1/2016