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 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: _____

GASTROENTEROLOGY ASSOCIATES, P.A.

Patient Name: _____ Gastro Provider: _____

Date of Birth: __ __ / __ __ / __ __ __ __

Why are you here today? _____

Please check any <u>persistent or recurring</u> symptoms you have: ☐ **I'm having no symptoms**

GI:
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Heartburn
- ☐ Reflux
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Vomiting
- ☐ Other:

General:
- ☐ Dizziness
- ☐ Fatigue
- ☐ Fever
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Weight loss
- ☐ Weight gain

Hematologic:
- ☐ Anemia
- ☐ Bleeding tendency

Neurological:
- ☐ Confusion
- ☐ Seizures
- ☐ Severe headache

Cardiovascular:
- ☐ Chest pain
- ☐ Irregular heart beats

Psychiatric:
- ☐ Depression
- ☐ Anxiety
- ☐ Panic attacks

Skin:
- ☐ Itching
- ☐ Rash
- ☐ Breast lumps
- ☐ Jaundice/yellow skin

ENT:
- ☐ Cough
- ☐ Hard of hearing
- ☐ Hoarseness
- ☐ Vision Changes

Genitourinary:
- ☐ Painful urination
- ☐ Frequent urination
- ☐ Trouble urinating

Musculoskeletal:
- ☐ Joint pain
- ☐ Muscle pain

Respiratory:
- ☐ Sleep apnea
- ☐ Shortness of breath

Do you have a history of:

Blood transfusions? Y / N
Tattoos? Y / N
Piercings? Y / N
IV Drug use? Y / N
Hepatitis A/B vaccinations? Y / N

Do you have heart stents? Y / N
Pacemaker? Y / N
Defibrillator? Y / N

Falling in the last year? Y / N
Recent ER visit? (Y / N) Date: _____
Flu shot? (Y / N) Date: _____

Marital status: Single / Married
Number of children: _____

Current Occupation/Employer:
_____

Former tobacco use? Y / N
Current tobacco use? Y / N
____ pack(s) per day for ____ year(s).

Do you drink caffeine? Y / N
____ drink(s) per day. Type: _____

Do you drink alcohol? Y / N
____ drink(s) per day. Type: _____

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

- ☐ High blood pressure
- ☐ Diabetes
- ☐ Coronary Artery Disease
- ☐ COPD
- ☐ Seizures
- ☐ Sleep Apnea
- ☐ Kidney disease
- ☐ Colon polyps
- ☐ Gallbladder Surgery
- ☐ Colon Surgery
- ☐ Other:_____
  _____
  _____

Surgeries: _____, _____, _____

Have you had a screening colonoscopy? (Yes / No) If yes, when? _____ Results? _____

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

Please check if you have a <u>family</u> history of the following, and then **<u>please specify relationship and age of diagnosis</u>.**

- ☐ 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)

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

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

☐ 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