GASTROENTEROLOGY ASSOCIATES, P.A.

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 medicines, vitamins, herbals, etc.
- Complete and bring all three (3) of the enclosed forms and questionnaires. Please do not mail. You can also visit our website gastroassociates.com to complete your forms electronically.
- Insurance cards (and Medicare D drug card if it applies)
- 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.

GASTROENTEROLOGY ASSOCIATES, P.A.

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: _____ Marital Status: _____

Race(check one): ☐White ☐Black or African American ☐ Hispanic ☐ American Indian or Alaska Native
☐Native Hawaiian or Other Pacific Islander ☐Asian ☐Other Race ☐Declined to specify

Ethnicity (check one): ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Decline to Specify

Preferred Language: _____

Primary Care Doctor: _____ Referring Doctor: _____

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

Cell Phone: _____ Home Phone: _____

Email: _____
(please provide so we can invite you to our patient portal)

Employer: _____

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

Primary Insurance Coverage

Name of Ins Co: _____ Member ID#: _____

Name of Subscriber: _____ Subscriber SS#: _____ Subscriber DOB: _____

Subscriber Employer: _____ Relationship to Subscriber: _____

Secondary Insurance Coverage

Name of Ins Co: _____ Member ID#: _____

Name of Subscriber: _____ Subscriber SS#: _____ Subscriber DOB: _____

Subscriber Employer: _____ Relationship to Subscriber: _____

GASTROENTEROLOGY ASSOCIATES, P.A.

CONSENT TO COMMUNICATE WITH YOU

Option 1 ☐ I authorize Gastroenterology Associates, PA to leave results or protected health information on my voicemail.

OR

Option 2 ☐ I authorize Gastroenterology Associates, PA to **only** leave a voicemail to return a call to your practice. *(no detailed health information).*

AUTHORIZATION TO COMMUNICATE WITH OTHERS

Option 1 ☐ _____ (initial) I **do not** authorize GA to communicate with anyone other than me.

OR

Option 2 ☐ I authorize Gastroenterology Associates, PA to discuss my protected health information (information in my medical record, diagnosis or treatment plans) and payment for my care with the individuals listed below. These individuals may also consent or authorize the disclosure of my protected health information.

				Medical	Billing
Name _____	Relationship _____	Phone _____		☐	☐
Name _____	Relationship _____	Phone _____		☐	☐
Name _____	Relationship _____	Phone _____		☐	☐

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/Authorized Representative (If patient is under the age of 18, legal guardian must sign.)

PATIENT PRIVACY NOTICE ACKNOWLEDGEMENT

Gastroenterology Associates, PA has provided their Notice of Privacy Practices and I understand how my privacy is protected.

X _____

Signature of Patient/Authorized Representative

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/Authorized Representative — Patient's Date of Birth

_____ _____

Print Name — Today's Date

Revised 3-26-21

OFFICE USE ONLY

If the above patient does not sign this form, please provide a reason why the acknowledgement was not obtained and witness.

Reason(s) _____

Witness / Staff Signature _____ Date _____

Name: | **DOB:** | **Reason for visit:**

GASTROENTEROLOGY ASSOCIATES, P.A.

Have you had a screening colonoscopy? ☐ Yes ☐ No If yes, when?_____

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

Gastrointestinal:
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Heartburn/Reflux
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Vomiting

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

Social History:

Tattoos? ☐ Yes ☐ No | **Piercings?** ☐ Yes ☐ No | **Current Employer**: _____

Marital status: ☐ Single ☐ Married **Number of children**: _____

Tobacco Use: ☐ Never ☐ Former ☐ Current (every day) ☐ Current (some days) **Type:**_____

Alcohol Use: ☐ Never ☐ Former ☐ Current (every day) ☐ Current (some days) **Type:**_____

Caffeine: ☐ Never ☐ Former ☐ Current (every day) ☐ Current (some days) **Type:**_____

IV Drug Use: ☐ Never ☐ Former ☐ Current (every day) ☐ Current (some days)

Recent ER visit? ☐ Yes ☐ No **Date:**_____ | **Fallen in the last year?** ☐ Yes ☐ No **Date:**_____

Any of the following vaccinations? ☐ Hepatitis A ☐ Hepatitis B ☐ Influenza (Flu) ☐ Other _____

Surgical History: (Check all that apply)

- ☐ Colon Surgery
- ☐ Hemorrhoid Surgery
- ☐ Gallbladder Surgery
- ☐ Gastric Surgery
- ☐ Liver Surgery
- ☐ Hysterectomy
- ☐ Laparotomy
- ☐ Obesity Surgery
- ☐ Thyroidectomy
- ☐ Tonsillectomy
- ☐ Transplant Surgery
- ☐ Small Intestine Surgery
- ☐ Appendectomy
- ☐ Breast Surgery
- ☐ C-section
- ☐ CABG/Heart Surgery
- ☐ Hernia Surgery
- ☐ Prostate Surgery
- ☐ Spinal Surgery
- ☐ Tubal Ligation
- ☐ Valve Replacement Surgery
- ☐ Other _____

Medical History: (Check all that apply)

- ☐ High blood pressure
- ☐ Coronary Artery Disease
- ☐ Heart Stent
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Atrial Fibrillation (AFIB)
- ☐ COPD
- ☐ Diabetes
- ☐ Seizures
- ☐ Sleep Apnea
- ☐ Kidney disease
- ☐ Blood Transfusion
- ☐ Anemia
- ☐ Colon Polyps
- ☐ Diverticulosis
- ☐ Ulcerative Colitis
- ☐ Crohn's Disease
- ☐ Hepatitis B
- ☐ Hepatitis C (HCV)
- ☐ Reflux
- ☐ Stomach Ulcers
- ☐ Cirrhosis
- ☐ Liver Disease
- ☐ Other: _____

Family History: (check all that apply and specify relationship)

	Relationship		Relationship
☐ Colon Cancer	_____	☐ Pancreas Cancer	_____
☐ Stomach Cancer	_____	☐ Prostate Cancer	_____
☐ Esophagus Cancer	_____	☐ Breast Cancer	_____
☐ Colon Polyps	_____	☐ Liver Disease	_____
☐ Crohn's Disease	_____	☐ Other _____	_____
☐ Ulcerative Colitis		☐ Other _____	

Allergies: (check all that apply)

- ☐ No known allergies
- ☐ Codeine Sulfate
- ☐ Versed
- ☐ Morphine
- ☐ Iodinated Contrast
- ☐ Fentanyl Citrate
- ☐ Propofol
- ☐ Penicillin
- ☐ Sulfa
- ☐ Demerol
- ☐ Latex
- ☐ Adhesive Tape
- ☐ Other _____
- ☐ Other _____

Medications: List current medications (including herbal and OTC) and dosage OR attach list

Name of drug	Strength/Frequency	Name of Drug	Strength/Frequency
1)		5)	
2)		6)	
3)		7)	
4)		8)	