Appt. Date: ____________________

Check in Time: _________________

Appt. Time: ____________________

With: _______________________

Welcome and thank you for choosing the **Centers for Gastroenterology** to provide your health care needs.

The physicians and staff of the **Centers for Gastroenterology** want your initial visit and ongoing relationship to progress as smoothly as possible. Be assured that if you identified a primary care or referring physician, our specialists will work closely with him/her in the diagnosis of your condition and in determining a plan of care. To that end, we request some assistance from you:

Please fill out the attached medical history form and patient information forms. You will get the most out of your visit by having your medical history completed, knowing the medications you are presently using, thinking of questions you have for the doctor, and being aware of any prescriptions refills you may need soon.

Medical records, lab reports and/or x-rays from your primary physician may be required for your visit. We will request these records for you at the time you schedule your appointment. However, if the referring office does not send the records, please be aware that your appointment may need to be rescheduled.

We do request payment for services at the time of your visit. Depending on your insurance coverage, this may be the entire fee, or it may be a visit co-payment. Our office takes payments by VISA, Master Card, Discover and American Express as well as a personal check or cash.

Please be sure to bring your insurance cards (and referral form, if your insurance company requires one) with you at the time of your visit. New identification protection regulations require photo identification on every visit: please bring a driver's license or state issued identification.

The Patient is responsible for notifying our office within two (2) business days to cancel an office appointment or within three (3) business days to cancel a scheduled procedure. A fee of $50 will be charged for office visit no shows or failure to cancel an office visit in 48 hours and a fee of $300 will be charged for no shows for scheduled procedures. Insurance will not cover these fees.

If you fail to show up on your initial office visit, a deposit of $100 will be required before you will be rescheduled for your visit. The $100 will be applied towards any balance due to the Centers for Gastroenterology. Any amount remaining after the balance due is paid will be refunded to you. If you no show again, you will not be rescheduled.

Our staff and our physicians are committed to providing you the best care and attention. We believe that a caring practice means taking time to get to know our patients and being sensitive to and aware of your needs. Please visit our website at **www.digestive-health.net** to learn more about our clinic. We sincerely look forward to meeting you.

Sincerely,
Centers for Gastroenterology

3702 S. Timberline Road
Fort Collins, CO 80525
970-207-9773

8225 W. 20th Street
Greeley, CO 80634
970-378-1414

2555 E. 13th Street, Ste. 220
Loveland, CO 80537
970-669-5432

Date of appointment: ________________________

Patient name: ____ Date of birth: _________________ Age: ___________

Primary care provider:_____________________________________Referring provider: ___________________________________

Reason for Visit Today (Select all that apply):

	Abdominal Distention		Abdominal Pain		Rectal Bleeding		Blood in Stool		Constipation
	Diarrhea		Nausea		Rectal Pain		Vomiting		Trouble Swallowing
	Incontinence		Heartburn		Acid Reflux (GERD)		Crohn's Disease		Irritable Bowel Syndrome
	Inflammatory Bowel Disease		Ulcerative Colitis		Achalasia		Barrett's Esophagus		Eosinophilic esophagitis
	Other								

To be filled out by nurse:

Preferred local pharmacy:_________________________________**Preferred mail order pharmacy:** ___________________________

Preferred laboratory for blood work:_______________________**Preferred radiology facility:** ______________________________

HT ________ **Weight** ________ **BP**_______/_______ **Pulse** _________ **Temp** _________

Immunizations: **Flu / When** ☐ / __________ **(65 or older) Pneumovax/When** ☐ / __________

Fallen within the last 3 months? Yes ☐ **No** ☐ **Fear of falling? Yes** ☐ **No** ☐ **Difficulty ambulating? Yes** ☐ **No** ☐

Patient Review of Systems

Please mark any conditions with which you have had symptoms in the last 2 weeks:

Constitutional	
	Appetite Change
	Fatigue
	Fever
	Unexpected Weight Change
HENT	
	Trouble swallowing
	Sore throat
Eyes	
	Vision problems
Respiratory	
	Apnea
	Cough
	Shortness of Breath
Cardiovascular	
	Irregular Heart Beat
	Chest Pain

Gastrointestinal	
	Abdominal bloating
	Abdominal pain
	Rectal Bleeding
	Blood in stool
	Constipation
	Diarrhea
	Nausea
	Rectal Pain
	Vomiting
	Nausea
Genitourinary	
	Painful Urination
Musculoskeletal	
	Joint pain
	Back Pain
	Trouble Walking

Skin	
	Skin Color Changes?
	Rash?

Neurological	
	Light-headedness
	Seizures
	Headaches

Hematologic	
	Swollen Glands

Behavioral Health	
	Nervous/Anxious
	Sleep Problems

Date of appointment: ________________________

Date of birth: ____________________ Age: _____________

Patient name: __________________________________

Tobacco Use

Current Everyday smoker	Current Some Day Smoker	Never	Former smoker	Passive Smoker	Heavy Smoker	Light Smoker

Comments on your history with tobacco:

Social History

Alcohol Use

Yes	Not Currently	Never

Drug Use

Yes	Not Currently	Never

Sexually Active

Yes	Not Currently	Never