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

Centers for Gastroenterology

Specialists in Digestive Health

Providing Care Since 1980

Patient Release Form

Would you prefer that we contact you through **My Health Connection** secure messaging? **Yes** **No**

Please leave us a confidential phone number in which we can leave a detailed message:______________________________

Who are we authorized to speak with**, other than you or your doctor?**___________________ ___________________

Name **Relationship**

___________________ ____________________

Name **Relationship**

By signing below I agree that:

- I understand that I am financially responsible to the Centers for Gastroenterology for any charges not covered by my insurance.
- I hereby assign all insurance payments for which I am entitled for medical or surgical services to the Centers for Gastroenterology.
- I authorize the Centers for Gastroenterology to release any medical information necessary to process my medical Insurance claims.
- I authorize the Centers for Gastroenterology to release all of my labs, procedures and test results to me.

_______________________________________ _____________________________________

Signature **Date**

_______________________________________ _______________________________________

Print Name **Date of Birth**

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

Patient name: ___________________________ Date of birth: ________________

GI Medical History:

	Y	Year diagnosed & Treatment received		Y	Year diagnosed & Treatment received
Celiac Disease			Cirrhosis		
Diverticular disease			Irritable bowel syndrome		
Ulcerative Colitis			Pancreatic cancer		
Gallbladder stones			Colon polyps		
Acid reflux			Liver disease		
Colon cancer			Rectal cancer		
Chronic constipation			Crohn's disease		
Hernia			Pancreatitis		
Esophageal cancer			Small intestine cancer		
Chronic diarrhea			Diverticulitis		
Hepatitis			Peptic ulcer		
Liver cancer			Stomach cancer		

Patient Medical History

Please mark ALL conditions which apply to you, the year diagnosed, and any treatment received:

	Y	Year diagnosed & treatment received		Y	Year diagnosed & treatment received
Thyroid disease			Glaucoma		
COPD / chronic bronchitis			Seizures		
Kidney disease			Cancer		
Anemia			Heart problems		
Depression			Stroke		
Nerve / muscle disease			Cataracts		
Anxiety			HIV/AIDS		
Diabetes mellitus			Substance Abuse		
Brittle bones (osteoporosis)			Bleeding problem		
Arthritis			High blood pressure		

Patient GI Surgical/Procedure History

Please mark ALL that apply with dates of GI surgeries/procedures:

Surgery/Procedure	Y	Date of surgery/ procedure	Surgery/Procedure	Y	Date of surgery/ procedure
Previous Surgeries			Colonoscopy		
Appendectomy			Stomach surgery for reflux		
ERCP procedure			Gall bladder removal		
Liver biopsy			Ultrasound during GI scope		
Colon/large intestine surgery			Liver surgery		
Polyp removal			Colostomy		
Small intestine surgery			Sigmoidoscopy		
Esophagus surgery			Stoma closure, Large Bowel		
Small Bowel Scope			Gastric Bypass		
Stomach surgery			Upper GI endoscope		

Patient name: ____ Date of birth: ______________________

Please mark ALL that apply and dates of any surgeries:

	Y	Date of surgery		Y	Date of surgery
Brain surgery			Fracture surgery		
Prostate surgery			Heart surgery		
Spine surgery			Hernia repair		
Plastic surgery			Heart valve replacement		
Eye surgery			Joint replacement		
Vasectomy					

Family History

Indicate if any blood relative has the following. (Please note which relative and if it's maternal or paternal)

Condition	Relative	Name	Comments
Celiac disease			
Cirrhosis			
Colorectal Cancer			
Colon polyps			
Cholangiocarcinoma			
Crohn's disease			
Cystic Fibrosis			
Esophageal cancer			
Gallbladder and bile duct cancer			
Gastric cancer			
Hemochromatosis			
Inflammatory bowel disease			
Irritable bowel syndrome			
Liver cancer			
Liver disease			
Pancreatic cancer			
Pancreatitis chronic			
Rectal cancer			
Stomach cancer			
Ulcerative colitis			
Wilson's disease			

Patient name: ____________________ Date of birth: ____________________

Tobacco Use History

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

Medications (please list if not attached):

Medication Name	Dose	Frequency

Medication Allergies (if any):

Name of allergen	Reaction/Date of Onset