Name_____ DOB_____
Last First MI

Address_____City _____State_____ZIP_____

Social Security Number_____ E-Mail Address_____

Age _____ Sex _____ Race _____ Ethnicity _____ Language _____

Employer_____Marital Status_____

Spouse's Name_____ DOB: _____
Last First MI

Spouse's Employer_____ Spouse's Social Security Number: _____

Please list reliable phone numbers that we may reach you on:
In the event that you are set up for any tests/procedures, we may disclose these numbers for said facilities to contact you.

Home phone:_____ Mobile phone:_____

Work phone:_____ Alternate :_____ Contact Name: _____

PRIMARY INSURANCE INFORMATION

Name of Insurance Company_____Policy Number_____Group_____

Policy Holder Name_____DOB_____Social Security Number_____

Place of Employment:_____ Relationship to Patient_____

SECONDARY INSURANCE INFORMATION

Name of Insurance Company_____Policy Number_____Group_____

Policy Holder Name_____DOB_____Social Security Number_____

Place of Employment:_____ Relationship to Patient_____

I,_____hereby give my permission for the doctor or the doctor's nurse to give the results of my lab tests, x-ray reports, and any other medical information that I may need to know to the persons listed below or to leave such information on my answering machine. I also authorize these said people pick up prescriptions and/or correspondence from the office in regards to my medical care.

ϒ _____ ϒ _____

ϒ _____ ϒ _____

I hereby give authorization to Digestive Health Center to furnish information to insurance carriers concerning my illness and treatments. I hereby assign all payments for medical services rendered to myself. I understand that I am responsible for all charges regardless of insurance coverage. I also authorize the release of my medical record information to other physicians or health care institutions for the purpose of continuity of care. This authorization should be considered for one year. ALL ABOVE INFORMATION IS TRUE TO MY KNOWLEDGE.

_____ _____

POLICY FOR PRESCRIPTIONS: It is important that our patients do not suffer any adverse effects from the medications prescribed by the physicians of Digestive Health Center. Serious side effects may result from using medications longer than intended. Some dangerous side effects may result from interaction of medications being prescribed by multiple physicians. If the physician prescribing medication is not aware of all medications being taken by the patient, it may result in adverse drug reaction. Please read the following and sign for our records.

(1) Medications will be refilled during normal business hours. Narcotics will be prescribed only by your treating physician.
(2) Prescriptions, especially narcotics, will not be prescribed on weekends, holidays or after hours by any of our physicians. Please make sure that you call and request any refills on medications before 4:00 PM each business day. Please be sure that your request coincides with your doctor's office hours. Your chart will be located in the office you were last seen. Therefore, please contact that office for any medication needs.
(3) We are a Gastroenterology practice and therefore we treat patients for gastroenterology problems. However, we do prescribe some narcotic pain medications based on a case by case basis. If your pain becomes chronic, we are not equipped to deal with chronic pain (requiring two or more prescriptions). We then will have to refer you to a pain management specialist. We will not replace lost narcotic prescriptions. We have also limited the number of pain medications that we prescribe per prescription. Therefore, it is imperative that we get your referred out to pain management if you require above our limit.

I understand the above terms of the prescription refills for Digestive Health Center.
_____**PATIENT INITALS**

ASSIGNMENT OF BENEFITS/AUTHORIZATION FOR TREATMENT: I hereby authorize treatment and authorize the provider of medical services from Digestive Health Center to release information for these services to my insurance carrier for payment. I further authorize that payment of benefits be made to the provider on my behalf or myself. I understand that I am financially responsible for all charges not covered by insurance. I AUTHORIZE THE RELEASE OF MEDICAL RECORDS INFORMATION TO OTHER PHYSICIANS OR OTHER HEALTH CARE INSTITUTIONS FOR THE PURPOSE OF CONTINUITY OF CARE.
_____**PATIENT INTIALS**

FINANCIAL POLICY-All of our providers at Digestive Health Center accept patients that have Medicare, Medicaid, Tricare, and the majority of commercial insurances. Please be aware that some services may not be covered under your insurance program, and therefore, you will be responsible for those charges. Any deductible and/or co-insurance will be due at the time of service. We do accept cash, check, major credit and debit cards.
_____**PATIENT INITALS**

In some circumstances payment plans can be made with our billing department. If lapses occur in making payments on such plans, and/or paying on balances due, our billing department will send the delinquent accounts to a collection agency. Any fees or expenses incurred as a result of sending your account to such agency will be the responsibility of the patient.
There will be a $30.00 fee for a returned check.
_____**PATIENT INITALS**

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICY: Attached to this paperwork is a PRIVACY NOTICE. I acknowledge that I have received the Privacy Notice of Digestive Health Center, P.A.
_____**PATIENT INITALS**

I have read and understand the terms of the assignment of benefits/authorization for treatment, financial policy/payment plan policy, consent form, and authorization for medical records. AUTHORIZATION EXPIRES IN ONE (1) YEAR

_____ _____
Patient or Authorized Representative **Date**

_____ _____

1. List your allergies: _____
_____
_____

2. What is the main reason for your visit today:

_____

_____

3. Circle any surgeries/ procedures you have had:

Appendectomy	hip/knee replacement	heart valve
Hysterectomy	eye/cataract	stomach
Bowel resection	shoulder/leg/arm	ERCP/pancreatic
Egd/Colonoscopy	Brain	hernia
Tonsils/adenoids	lung	weight loss
Gallbladder	heart stents/bypass	cyst removal

4. Circle any symptoms you are experiencing today:

Nausea and vomiting	abdominal pain
Diarrhea/ constipation	sharp, dull, stabbing, burning
Rectal bleeding	upper abdomen/ lower abdomen
Hemorrhoids	constant/intermittent
Heartburn	difficulty swallowing

5. List your medications with dosage and frequency:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

6. Circle any of your own past medical history:

Reflux/ swallowing difficulty	staph infection (location) _____
Crohns disease	COPD/asthma
Ulcerative colitis	Diabetes
Barretts esophagus	Hypertension
Gallstones	Pancreatitis
Cancer _____	Hepatitis A, B, C
Heart disease	Liver disease (fatty liver, cirrhosis)
Seizures/stroke	Kidney problems (stones, failure, dialysis)
Blood clots	Brain Injury
Ulcers	Depression

7. If you are in pain today, please rate that pain intensity:

Very Mild 1 2 3 4 5 6 7 8 9 10 Extreme

8. Pertinent Family Medical History:

Mother _____
Father _____
Brothers _____
Sisters _____
Paternal Grandmother _____
Paternal Grandfather _____
Maternal Grandmother _____
Maternal Grandfather _____

Authorization to release Health Information

I understand that I have the right to request restrictions as to how my private health information may be disclosed. In my absence, I hereby authorize the release of test results and/or medical information, including billing and appointment information, to the following:

Only check those that apply. Please specify the name for the person where applicable.

Patient Name: _____ DOB: _____

_____ Spouse: _____
_____ Family Member: _____Relation: _____
_____ Family Member: _____Relation: _____

_____ Leave Message on answering machine at HOME regarding my appointments or text my cell.

_____ Other: _____

I understand I have the right to revoke this permission in writing at any time, except to the extent that Memorial Physicians Clinics physicians have already taken action.

_____ _____
Patient Signature Date

_____
Name and relationship to patient (if signed by a personal representative of the patient)

_____ _____
Witness Date

Bowel Symptom Questionnaire

Name: _____Date: _____
Doctor: _____

Which symptoms best describe you? Select all that apply.

- Accidental loss of leakage of stool – sometimes unable to make it to the bathroom in time
- Bowel accidents while unaware – no warning and/or while asleep
- Frequent loose, watery stools
- Sudden or strong urge to go to the bathroom
- Bowel accidents when passing gas
- No bowel problems (if checked, please discontinue questionnaire)

How long have you had these symptoms?
Approximately how many bowel incidents do you have per week?
Have you tried medications to help your symptoms ? Yes No
On a scale of 1 to 10, with 0 being no symptom relief and 10 being complete symptom relief, how much symptom relief have these medications provided for you? Select Number .

1	2	3	4	5	6	7	8	9	10

No relief *Complete Relief*

Behavior modifications tried?

On a scale of 1-10, with 1 being no frustration at all and 10 being extremely frustrated, what is your level of frustration with your bowel control symptoms? Select a number.

1	2	3	4	5	6	7	8	9	10

Not frustrated *very frustrated*

Are you interested in learning more about additional treatment alternatives to bowel medications? Yes No