Gastroenterology Associates-Demographics

Date: _____ **Chart #:** _____

Name: _____

Address: _____

City: _____

State, Zip: _____

Home Phone: _____

Mobile Phone: _____

County: _____

Preferred Contact Method: _____

Emergency Phone different from patients: _____

_____

Emergency Contact Name and Relationship: _____

_____

Patient Email: _____

Birth date/Age: _____

Sex: _____

Marital Status: **(Married, Single, Divorced, Widow)**

Race: **African American, Asian, White, Native American, And Other**: _____

Ethnicity: **Hispanic, Non-Hispanic, Unknown**:

Preferred Language: _____

SS#: _____

PCP: _____

Referring M.D: _____

Do have a living will? **Yes / No**

****

Have you ever had a colonoscopy? **Yes / No**

When _____Dr. _____ Polyps_____

Have you or any family member ever experienced a condition called Malignant Hyperthermia, which is a condition that can cause trouble with anesthesia when being put to sleep? **Yes / No**

Any upcoming heart or breathing tests? **Yes / No**

If yes, please list the name of test and date scheduled:

_____

Patient's Employer:_____

Retired? **Yes / No**

Employer Phone #: _____

Spouses Name: _____

Date of Birth: _____

Spouses SS# (for insurance purposes):_____

Spouse's Contact Phone#:_____

Patient's Primary Insurance:_____

Insurance Phone#: _____

Insurance ID #: _____

Is insurance in your name? **Yes / No**

If no, what is your relationship to subscriber, subscriber's name and date of birth:_____

_____

Patient's Secondary insurance:_____

Insurance phone #: _____

Insurance ID #: _____

Is insurance in your name? **Yes / No**

If no, what is your relationship to subscriber, subscriber's name and date of birth:_____

Local Pharmacy **(required)** – Name, phone number, and location: _____

_____

Mail Order Pharmacy – Name, phone number, and location: _____

****

Height: _____ Weight: _____

Are you currently on dialysis? **Yes / No**

Do you have an automatic implantable defibrillator? (Pacemaker)? **Yes / No**

Do you have difficulty walking? **Yes / No**

Are you currently having bowel problems? **Yes / No**

If yes, please explain:_____

HIPAA Privacy Acknowledgement

1. May we call the telephone number you provided and leave a message on an answering machine or with a family member/friend regarding your appointment or test results? Yes____ No_____.
   If No, is there another number we may use to reach you?
   Area Code:_____ Phone Number: _____
   May we call you at work? Yes _____ No_____ Work Phone Number: _____

2. May we mail information to your home address regarding your appointments or test results?
   Yes____ No ____
   If NO, is there another address to which we may send your information? Please provide that mailing address: _____

3. Please list a family member (s) with whom we may release your medical information if needed:

Name	**Area Code and Phone Number**	**Relationship**

Please note that we can only release your medical information to the person (s) listed above.

4. A copy of the Physician's Practice "Notice of Privacy Practices for Protected Health Information" is located in the front office lobby and a copy available upon request.

I have read the HIPPA Privacy Acknowledgement and understand the information provided is ongoing unless I provide updated information to Gastroenterology Associates. For changes, please see the receptions.

_____ _____
Signature Date

INSURANCE INFORMATION

Patient and /or guarantor are responsible for charges incurred. You are responsible on the day of your visit for your co-pay and /or percentage, for which your insurance company is not liable. If we are unable to obtain payment within a reasonable amount of time form the patient and /or guarantor, we will place your account with a collection agency, which will leave you liable for additional expenses incurred if applicable.

I have read and understand the above statement of payment policy. I hereby request any benefits on my behalf be paid to the physicians. I also authorize the release of any information required in the course of my treatment to my insurance company as needed to issue benefits.

_____ _____
Signature Date

I request that payment of authorized Medigap (Medicare Supplement) benefits be made on my behalf to the provider for services furnished me by that provider. I authorize any holder of medical or other information about me be released to my Medigap Insurer to determine these benefits payable for released services.

_____ _____
Signature Date

MEDICARE "B" SIGNATURE AUTHORIZATION

I authorize any holder of medical or other information about me be released to the Social Security Administration and Centers for Medicare and Medicaid Services or it's intermediaries or carriers, or to the billing agent of this physician or supplier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the party who accepts assignment.

I understand that this is a lifetime authorization.

_____ _____
Signature Date

Gastroenterology Associates

NO SHOW/CANCELLATION POLICY

CHART# _____

In order to provide good patient care, we ask that patients notify the office a minimum of 24 hours in advance if unable to keep your scheduled appointment time. This policy has been developed in order to provide appointments for those who are sick and need to be seen. If someone makes an appointment and then does not show or repeatedly cancels, we have then lost an available appointment that could have been used for a sick patient.

We need to inform you as per Gastroenterology Associates Policy that after two no-shows or cancelled appointments, you may be dismissed from all Gastroenterology Associates providers. **There will be a $30.00 charge for missing a scheduled office appointment or for cancelling or rescheduling without a 24 hour notice.** We will try to accommodate your needs as the schedule allows but understand sometimes providers are scheduled out months in advance and you may have to wait an extended period of time for the rescheduled appointment/procedure.

Please sign below as affirmation that you have read and understand Gastroenterology Associates' policy regarding no shows and cancellations.

Patient Signature_____

Date_____

Witness_____

ECB
THE ENDOSCOPY CENTER OF BRISTOL, LLC

NO SHOW/CANCELLATION/RESCHEDULE POLICY

We understand that scheduling conflicts occur from time to time however, we request at least 24 hours advance notice if you are unable to keep your scheduled appointment. **There will be a $100.00 charge for missing a scheduled procedure appointment or for cancelling or rescheduling without a 24 hour notice.** Two no-shows, cancellations, and/or reschedules may result in your dismissal from all The Endoscopy Center of Bristol providers.

This policy has been developed in an effort to better serve our patients by providing procedure appointments in a timely manner. If someone schedules an appointment and then does not show, cancels or reschedules we have lost an available appointment that could have been used for a sick patient. We will try to accommodate your needs as the schedule allows but understand sometimes providers are scheduled out months in advance and you may have to wait an extended period of time for the rescheduled appointment/procedure.

Please sign below as confirmation that you have read, acknowledged and understand The Endoscopy Center of Bristol policy regarding no shows, cancellations and reschedules.

Patient Signature_____

Date_____

Effective 11/4/2019

Gastroenterology Associates
235 Medical Park Blvd. Bristol, TN 37620
Phone (423) 274-6350
FAX (423)245-5439 or (423)245-7191

Patient Interview Form

Patient Information

First Name:_____ Last Name:_____

MRN:_____ Date Of Birth:_____

Age:_____ Notes:_____

Email
Please check one as your preferred email for communications

☐ Personal:_____ ☐ Work:_____

Race
Select one or more

☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander

☐ Unknown ☐ Patient declines to specify ☐ Prohibited by state law

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient declines to specify ☐ Prohibited by state law

Sex

☐ Male ☐ Female ☐ Other

Preferred Language

☐ English ☐ Spanish; Castilian ☐ Patient declines to specify

Contact Preference

☐ Letter ☐ Primary Telephone Number:_____ ☐ Email Address:_____

☐ Cell Phone Number:_____ ☐ Work Number:_____ ☐ Patient declines to specify

Allergies

☐ Patient has no known allergies ☐ Patient has no known drug allergies

☐ Aspirin ☐ Codeine ☐ Demerol ☐ Iodine ☐ Latex

☐ Morphine ☐ Novocain ☐ Penicillins ☐ Propofol ☐ Sulfa

☐ Surgical Tape ☐ Versed Other:_____

Immunizations

- ◯ None
- ◯ Flu vaccine When:_____
- ◯ Hep B When:_____
- ◯ Hep A When:_____
- ◯ Pneumonia When:_____
- ◯ Shingles When:_____
- ◯ TB Skin Test When:_____
- ◯ Tetanus When:_____

Diagnostic Studies/Tests

- ◯ None
- ◯ Lab Work When:_____
- ◯ X-Rays When:_____
- ◯ Stool Studies When:_____
- Other:_____
- Other:_____

Past or Present Medical Conditions

- ◯ None

GI Related

- ◯ Anemia
- ◯ Chronic Constipation
- ◯ Cirrhosis of Liver
- ◯ Colitis
- ◯ Colon cancer
- ◯ Colon Polyps
- ◯ Crohn's Disease
- ◯ Diarrhea
- ◯ Diverticulitis
- ◯ Diverticulosis
- ◯ Duodenal Ulcer
- ◯ Fatty Liver
- ◯ Gallstones
- ◯ Hepatitis A
- ◯ Hepatitis B
- ◯ Hepatitis C
- ◯ Hiatal Hernia
- ◯ Irritable Bowel Syndrome
- ◯ Lactose Intolerance
- ◯ Pancreatitis
- ◯ Reflux
- ◯ Stomach Ulcer
- ◯ Ulcerative Colitis
- ◯ Port a Cath

Other:_____

General

- ◯ Asthma
- ◯ Atrial Fibrilation
- ◯ Back Pain (chronic)
- ◯ Breast Cancer
- ◯ Cancer
- ◯ Chronic Lung Disease
- ◯ Congestive Heart Failure
- ◯ Depression
- ◯ Diabetes Mellitus
- ◯ Emphysema
- ◯ Frequent Urinary Tract Infection
- ◯ Glaucoma
- ◯ Gout
- ◯ Heart Attack
- ◯ Heart Murmur
- ◯ High Blood Pressure
- ◯ High Cholesterol
- ◯ High Triglycerides
- ◯ History of Suicide Attempts
- ◯ HIV/AIDS
- ◯ Irregular Heart Beat
- ◯ Kidney Disease
- ◯ Kidney Failure
- ◯ Kidney Stone
- ◯ Lupus
- ◯ Migraines
- ◯ Osteoarthritis
- ◯ Paralysis
- ◯ Parkinson's Disease
- ◯ Phlebitis
- ◯ Pneumonia
- ◯ Rheumatic Fever
- ◯ Rheumatoid Arthritis
- ◯ Seizures
- ◯ Skin Cancer
- ◯ Sleep Apnea
- ◯ Stroke
- ◯ TB (Tuberculosis)
- ◯ TB Skin Test Positive
- ◯ Uterine Cancer

Other:_____

- ◯ Malignant Hypothermia
- ◯ hemorrhoids
- ◯ thyroid disorder

Previous Procedures

- ☐ None
- ☐ Appendectomy
- ☐ Breast surgery/cosmetic
- ☐ Breast surgery/cancer
- ☐ Cardiac Surgery
- ☐ Colonoscopy
- ☐ C-Section
- ☐ EGD/Upper Endoscopy
- ☐ ERCP
- ☐ Gallbladder/ Cholecystectomy
- ☐ Heart Bypass Surgery
- ☐ Heart Stent
- ☐ Heart Valve Replacement
- ☐ Hemorrhoid surgery
- ☐ Hernia Repair
- ☐ Hysterectomy Partial
- ☐ Hysterectomy Total
- ☐ Joint Surgery/ Replacement
- ☐ Kidney
- ☐ Obesity Surgery
- ☐ Prostate
- ☐ Stomach
- ☐ Thyroid surgery
- ☐ Tonsils
- ☐ Transplant Surgery
- ☐ Tubal Ligation
- ☐ Vasectomy

Other: _____ Other: _____

Social History

Occupation: _____ Number of Children: _____

Marital Status

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ Widowed
- ☐ Civil Union
- ☐ Unknown
- ☐ Other

Alcohol

- ☐ None

Type	Quantity	Number	Frequency
☐ Beer			Times / week
☐ Wine			Times / week
☐ Liquor			Times / week

Caffeine

○ None

Intake:_____

Tobacco

Smoking Status

○ Current every day smoker ○ Current some day smoker ○ Former smoker ○ Never smoker

○ Smoker, current status unknown ○ Light tobacco smoker ○ Heavy tobacco smoker ○ Unknown if ever smoked

Type	Started	Quit	Quantity	Frequency
○ Cigarettes				Packs / Day
○ Cigar				Times / week
○ Smokeless				Times / week

Drug Use

○ None

Type	Quantity	Number	Frequency
○ Illicit Drugs			
○ Injection Drug Use			

Exercise

○ None

Type	Quantity	Number	Frequency
○ Aerobics			
○ Bike			
○ Golf			
○ Jog			
○ Lift Weights			
○ Swim			
○ Walk			

Consent to Share Data

I consent to having my medical and demographic information shared with other health care entities.

◯ Yes ◯ No

Reminder Preference

I would like to receive preventive care and follow up care reminders.

◯ Yes ◯ No

Consent to Import Medication History

I consent to obtaining a history of my medications purchased at pharmacies.

◯ Yes ◯ No

Reviewed with

◯ Patient ◯ Parent ◯ Guardian ◯ Not Present

FAMILY MEDICAL HISTORY

Patient Name: _____ Date of birth: _____

Please indicate if your family members are "LIVING" or "DECEASED". Tell us about the illnesses that have occurred with your family members that are "living". If any family members are "deceased", please list the age of death and cause of death if you know.

FAMILY	LIVING	IF LIVING LIST ILLNESSES (describe any illness that are present)		DECEASED LIST AGE @ DEATH	IF DECEASED INDICATE CAUSE OF DEATH IF KNOWN
MOTHER					
FATHER					
SISTER'S					
" "					
" "					
BROTHER'S					
" "					
" "					
DAUGHTER'S					
" "					
" "					
SON'S					
" "					
" "					

Check the circle provided if anybody in your family has had the following diseases:

o ULCERATIVE COLITIS o CROHN'S DISEASE

o COLON CANCER

Which family member/members had colon cancer and at what age? _____

o COLON POLYPS

Which family member/members had colon polyps and at what age? _____

Medication List

Please complete the information below.

Today's date: _____ Chart Number: _____

Name: _____ Date of birth: _____

Drug allergies: _____

List all current medications that you currently take, including vitamins, over the counter medications and herbal preparations.

Medication Name (Please Print Clearly)	Dosage	Frequency (How often per day)

(Additional medications can be written on the back of this sheet if needed) >>>>>>