NGA NORTHLAKE GASTROENTEROLOGY ASSOCIATES

Physicians:
Gregory Mula, M.D. • Lawrence Gensler, M.D. • Dennis Booth, Jr. M.D. •
Jason Reina, M.D. • Russell Wardlaw, M.D.

Nurse Practitioners:
Wendy Peterson, NP • Alisa Picou, NP • Wendi Neal, NP •
Whitney Morgan, FNP-C • Alexandra Morgan, FNP-c

NEW PATIENT REGISTRATION

Patient Information (Confidential)

MRN: _____

Name: _____
(last) (first) (middle)

Maiden Name: _____ Alias/Nickname: _____ Birthdate: _____ Age: _____

Address: _____ Cell #: (_____) _____-_____

City: _____ State: _____ Zip code: _____ Home #: (_____) _____-_____

E-Mail: _____ SSN: _____-_____-_____

Sex: ☐ Male ☐ Female ☐ Other (specify): _____

Preferred Language: ☐ English ☐ Spanish ☐ Sign Language ☐ Other(specify): _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Married ☐ Unemployed

Spouse Name: _____ Phone: (_____) _____-_____

Do you give Northlake Gastroenterology Associates Permission to release protected health information to the spouse listed above? ☐ Yes, I do give permission ☐ No, I do not give permission

Emergency Contact: _____ Phone: (_____) _____-_____

Emergency Contact relationship to patient: _____

Preferred Communication Method:	☐ E-Mail ☐ Phone	Primary Phone:	☐ Cell ☐ Home ☐ Work

Ethnicity:	☐ Hispanic or Latino	☐ Not Hispanic or Latino	☐ Patient declines to specify	☐ Unknown
Race:	☐ White/Caucasian	☐ Black or African American	☐ American Indian/Alaska Native	☐ Asian
	☐ Native Hawaiian	☐ Other Pacific Islander	☐ Patient declines	☐ Unknown
	☐ Other: _____			

If college student, ☐ full-time ☐ part-time , Name of School: _____

Patient or Guarantor's Employer Name: _____

Employer Address : _____ Work #: (_____) _____-_____

City: _____ State: _____ Zip code: _____ Work # Extension: _____

Who referred you to Northlake Gastroenterology Associates?

_____

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Responsible Party (parent/guardian/power of attorney (POA))

Name of person legally and financially responsible for this account:

_____

(last) (first) (middle)

Relationship to the patient: _____ Birthdate: _____ Age: _____

Address: _____ Cell #: (_____) _____-_____

City: _____ State: _____ Zip code: _____ Home #: (_____) _____-_____

E-Mail: _____ SSN: _____-_____-_____

Driver's License #: _____ Date Issued: _____/_____ State Issued: _____ Expiration: _____/_____

Referring Physician or Primary Care Physician

Physician Name: _____ Phone #: (_____) _____-_____

Physician Office Name: _____ Fax #: (_____) _____-_____

Physician Address: _____

City: _____ State: _____ Zip Code: _____

Pharmacy Information:

Pharmacy Name: _____ Phone #: (_____) _____-_____

Pharmacy Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Information

Primary Insurance Company: _____

Member/Subscriber Id # : _____ Group # : _____

Subscriber Name: _____ SSN: _____-_____-_____ DOB: ___/____/_____

Patient's Relationship to Subscriber: ☐ Self ☐ Child ☐ Spouse ☐ Employee ☐ Other (specify): _____

Secondary Insurance Company: _____

Member/Subscriber Id # : _____ Group # : _____

Subscriber Name: _____ SSN: _____-_____-_____ DOB: ___/____/_____

Patient's Relationship to Subscriber: ☐ Self ☐ Child ☐ Spouse ☐ Employee ☐ Other (specify): _____

_____ _____ _____/_____/_____

Patient Name (print) Patient Signature Today's Date

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Consent for Treatment, Disclosure of Health Information, & Patient Communication Form

Consents:

- I consent to obtaining a history of my medications purchased at pharmacies.
- I consent to having my full medical record and demographic information shared with other healthcare entities including but not limited to referring/requesting providers & healthcare facilities not affiliated with Northlake Gastroenterology Associates, insurance carriers, etc.

Reminder Preference:

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

It is the policy of Northlake Gastroenterology Associates not to release confidential information regarding your treatment to family members or friends, except for (1) parent/legal guardian of minor patients, (2) other persons authorized by the patient in this disclosure below.

You may disclosure of my health information to the following people:

NAME	*RELATIONSHIP*	*PHONE*	*EMERGENCY CONTACT:*
		( )	☐ Yes / ☐ No
		( )	☐ Yes / ☐ No
		( )	☐ Yes / ☐ No
		( )	☐ Yes / ☐ No

Accompanying person:

- If you bring a family member or friend into the exam room, we will assume, unless you object, that the person is entitled to receive information regarding your treatment, in emergency or other as permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Alternative Communication:

- You are entitled to specify alternative, reasonable means of communication, if you do not wish to be contacted by us in a certain way.

_____ Patient Name (print)

_____ Patient Signature

_____/_____/_____ Patient Date of Birth

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Patient Waiver and Release

1. Notice of Increased Risk
    a. Patient acknowledges that there exists a public health emergency due to the Coronavirus Disease 2019 (COVID-19)/infection with SARS-CoV-2. Patient further acknowledges that the Louisiana Department of Health has directed Louisiana-licensed facilities, including Northlake Endoscopy, L.L.C. ("Northlake Endoscopy"), and Louisiana-licensed physicians to postpone all medical and surgical procedures unless the procedure cannot be safely postponed. Patient has discussed with Patient's physician the risks and benefits of postponing Patient's scheduled procedure at Northlake Endoscopy and consents to proceed with the procedure. Northlake Endoscopy and its physicians, contractors, and employees are taking all reasonable precautions to prevent the spread of the SARS-CoV-2 virus to Northlake Endoscopy's patients and staff. Nevertheless, Patient understands that Patient faces an increased risk of COVID-19/ infection with SARS-CoV-2 by proceeding with Patient's medical or surgical procedure during the public health emergency.
2. Waiver and Release
    a. Patient, including Patient's heirs, legatees, and estate, waives and releases any and all claims against Northlake Endoscopy, Northlake Gastroenterology Associates, L.L.P., a Louisiana limited liability partnership, and their directors, officers, owners, contractors and employees (collectively "Northlake Parties") with respect to any and all sickness, injury, disability, complication or death, caused by possible infections, viruses, illnesses, or diseases, including but not limited to COVID-19/infection with SARS-CoV-2. Patient, including Patient's heirs, legatees, and estate, agrees to not file suit against any of the Northlake Parties on the basis of these waived and released claims. Patient, including Patient's heirs, legatees, and estate, will defend, indemnify, and hold the Northlake Parties harmless from and against any and all liability, loss, damages, claims, and attorney's fees that may be suffered by Northlake Parties resulting directly or indirectly from any and all sickness, injury, disability, complication, or death caused by possible infections, viruses, illnesses, or diseases, including but not limited to COVID-19/infection with SARS-CoV-2.

_____	_____	_____/_____/_____
Patient Name (print)	Patient Signature	Patient Date of Birth

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Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of your Financial Policy which we require you to read and sign prior to any treatment.

All patients must complete our Information and Insurance Form before seeing the doctor.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE, IF YOU HAVE NOT MET YOUR DEDUCTIBLE WITH YOUR INSURANCE COMPANY FOR THE YEAR. ALL COPAYS ARE DUE UPON COMPLETION OF YOUR VISIT. WE ACCEPT CASH, CHECK, OR VISA/MASTERCARE, AMERICAN EXPRESS.

Regarding Insurance:

- We will accept, as a courtesy, assignment of your insurance benefits after you have met your deductible and paid your copay.
- Upon your first visit and any visit in the future if you have not met your deductible, you will have to pay in full until your deductible for that year is satisfied.
- The balance is your responsibility whether your insurance company pays or not.
- We cannot bill your insurance company unless you give us your insurance information. We will ask for your insurance card at each visit to scan into the health record.
- Your insurance policy is a contract that between you and your insurance company. We are not a party of that contract.
- If your insurance company has not paid your account in full within 45 days of the billed claim date, the balance will be transferred to for full payment.
- Please be aware that some, and perhaps all the services provided may be non-covered and not considered reasonable and necessary under the Medicare program and/or other medical insurance policies/carriers.

Usual and Customary Rates:

- Our practice is committed to providing the best treatment for our patients. We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Adult Patients:

- Adult patients are responsible for full payment at the time of service.

Minor Patients:

- The adult accompanying a minor and the parent/guardian are responsible for full payment at the time of service. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, approved credit card, or payment by cash or check at the time of service.

PLEASE KNOW THAT YOUR PHYSICIAN MAY BE AN OWNER IN THE FACILITY THAT YOUR PROCEDURE WILL BE SCHEDULED AT.

If you have a check returned or a charge back on a credit card, your account will be charged a $45.00 fee.

Thank you for understanding our financial policy. If you have any questions, please let us know.

I IRREVOCABLY ASSIGN AND TRANSFER PAYMENT OF MEDICAL BENEFITS TO: NORTHLAKE GASTROENTEROLOGY ASSOCIATES. A PHOTOSTATIC COPY OF THIS AUTHORIZATION WILL BE CONSIDERED EFFECTIVE AND VALID AS THE ORIGINIAL. I FURTHER AUTHORIZE RELEASE OF ALL RECORDS NECESSARY TO MY INSURANCE COMPANY, ATTORNEY, AND/OR OTHER REFERRING PHYSICIANS.

By signing below, I acknowledge that I have read and understand the financial policy of Northlake Gastroenterology Associates and its affiliates in full.

Name (print): _____ Date of Birth: _____/_____/_____

Signature: _____ Today's Date: _____/_____/_____

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Keeping your privacy:

- Protecting your privacy and your medical information is at the core of our business. We recognize our obligation to keep your information secure and confidential whether on paper of the Internet. At NORTHLAKE GASTROENTEROLOGY ASSOCIATES (hereinafter referred to as "the Practice"), privacy is one of our highest priorities.

Keeping your information:

- Keeping the medical and health information we have about you secure is one of our most important responsibilities. We value your trust and will handle your information with care. Our employees access information about you only when necessary to provide treatment, verify eligibility, obtain authorization, process claims and otherwise meet your needs. We may also access information about you when considering a request from you or when exercising our rights under the law or any agreement with you.
- We safeguard information during all business practices according to established security standards and procedures, and we continually assess new technology for protecting information. Our employees are trained to understand and comply with these information principles.

Working to meet your needs through information:

- While doing business, we collect and use various types of information, like name and address and claims information. We use this information to provide service to you, to process your claims to bring your health information that might be of interest to you.

Keeping your information accurate:

- Keeping your health information accurate and up to date is very important. If you believe the health information, we have about you is incomplete, inaccurate, or not current, please call or write us at the telephone numbers or addresses listed below. We take appropriate action to correct any erroneous information as quickly as possible through a standard set of practices and procedures.

How your information is shared:

We limit who receives information and what type of information is shared.

- Sharing information within the Practice. We share information within our company to deliver you the health care services, and the related information and education programs specified in your plan.
- Sharing information with companies that work for us. To help us offer you our services, we may share information with companies that work for us, such as claim processing and mailing companies and companies that deliver health education and information directly to you. These companies act on our behalf and are obligated contractually to keep the information that we provide them confidential.
- Other Patient-specific personally identifiable data is released only when required to provide a service for you and only to those with a need to know, or with your consent. Data is released with the condition that the person receiving the data will not release it further unless you give permission.

If we receive a subpoena or similar legal process demanding release of any information about you, we will attempt to notify you (unless we are prohibited from doing so). Except as required by law or as described above, we do not share information with other parties, including government agencies.

The practice does not share any customer information with third-party marketers who offer their products and services to our patients.

Count on our commitment to your privacy:

- You can count on us to keep you informed about how we protect your privacy and limit the sharing of information you provide to us - whether it's at our office, over the phone or through the internet.

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By signing below, you acknowledge that you have read, understand, and agree with the terms in this privacy notice. Please let our staff know if you would like them to print our signed copy upon completion of all consents.

Name (print): _____ Date of Birth: _____/_____/_____

Signature: _____ Today's Date: _____/_____/_____

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Informed Consent for Telehealth Services

1) I understand that my healthcare provider offers telehealth services and I wish to engage in a telehealth visit. I will not be in the same physical location as my healthcare provider, but my healthcare provider will use the same standard of care as if the services were being provided in person.
2) I understand that telehealth visits are available as an alternative to traditional "face to face" visits. My healthcare provider has explained to me how to use the telehealth technology, and while my provider uses technology and equipment that is believed to be reliable, nothing is failsafe. A failure could cause the following: a. my care could be delayed; b. poor image resolution may interfere with appropriate medical decision making; or c. telehealth network and software security protocols which protect the confidentiality of my medical information could fail, causing my personal information to be inappropriately revealed. If there is an equipment or technology failure, I will call the phone number provided above.
3) I understand that I may choose to stop any telehealth visit or to withdraw my consent to telehealth services and care at any time. If I choose to withdraw my consent for telehealth services, it will not affect my right to future care, treatment, benefits, or programs to which I am otherwise entitled. Alternative methods of care may be available and have been discussed with me.
4) In the event of an emergency, I will call 9-1-1. For non-emergency questions or calls, I will call the number provided above.
5) My telemedicine medical record may contain recordings of my physical image, medical images, interactive audio, video, data communications, output data from medical devices, and other related sound and video files. This information will only be used for documentation and/or health care purposes and these records will be kept by my healthcare provider for diagnosis, treatment, follow-up, and/or education.
6) All HIPAA requirements for retention and disclosure of my medical records, as well as the HIPAA requirements for a privacy notice, are applicable to telehealth. I have been provided with my healthcare provider's Notice of Privacy Practices.
7) I may request to get a copy of my telehealth medical records, including having them sent to another physician. To obtain my medical records, I will call the phone number provided above.
8) I have read and understand the information provided above regarding telehealth, have discussed it with my healthcare provider, and all my questions have been answered to my satisfaction. I consent to participate in telehealth visits.
9) **Cost-shares such as COPAYS, COINSURANCE, AND/OR DEDUCTIBLE may apply to your telehealth visit and will be collected by phone the day before the visit. These amounts must be collected per our legal contract with your insurance carrier.**

By signing below, I acknowledge that I have read and understand the telehealth policy of Northlake Gastroenterology Associates and its affiliates in full.

Name (print): _____ **Date of Birth: _____/_____/_____**

Signature: _____ **Today's Date: _____/_____/_____**

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Release of Medical Records

Pt Name: _____ DOB: ____/____/_____

I, _____, hereby authorize:

(Patient Name)

Facility / Physician Name: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone: (_____)_____-_____ Fax: (_____)_____-_____

To disclose the following specific health information to:

☐ Northlake Gastroenterology Associates
(Hammond & Franklinton locations)
16061 Doctors Blvd., Suite B
Hammond, LA 70403
Phone: (985) 542-1334
Fax: (985) 542-8643

☐ Northlake Gastroenterology Associates
(Covington location)
7015 HWY 190 E Service Rd, Ste 102
Covington, LA 70433
Phone: (985) 893-9592
Fax: (985) 801-0113

From my personal and confidential health record for the purpose of:

☐ Medical Treatment ☐ Other (Specify): _____

My authorization extends to the data elements/documents checked below:

☐ Records of office visits

☐ Labs and Radiology

☐ Records pertaining to a specific date or date range as listed here:
_____through_____

☐ Other
(Specify):_____
_____

This authorization is given freely with the understanding that: 1) Any and all records, whether written, oral, or electronic format, are confidential and cannot be disclosed without my prior written authorization. 2) A photocopy or fax of this authorization is a valid as the original. 3) I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a one-year period from the date it is signed, or sooner if noted below. The revocation must be in writing. A revocation form is available from the receptionist. 4) Northlake Gastroenterology Associates, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. 5) Treatment, payment, enrollment, or eligibility for benefits may not be conditioned upon obtaining this authorization. 7) Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and is no longer protected.

_____	_____	_____
Print Patient Name	Representative Authority to Act	Expiration Date -if other than 1 year
_____	_____	_____
Patient, Guardian, POA signature	Today's Date	Witness (desk clerk if no other witnes

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PATIENT INTERVIEW FORM

Patient Name: _____ D.O.B: _____/_____/_____

Family Medical History *(1st degree relatives only (i.e., mother/father/sister/brother))*

Deceased:	**If deceased, please list cause of death:**
☐ Mother	
☐ Father	
☐ Sister	
☐ Brother	
☐ History unknown	

Does any of your immediate family have or had any of the following (please check any that apply and check which family member had the condition in the table below.

Condition/Disease:	**Family member:**
☐ Colon Cancer	☐ Mother ☐ Father ☐ Sister ☐ Brother
☐ Cancer (other than Colon Cancer)	☐ Mother ☐ Father ☐ Sister ☐ Brother
Type:	
☐ Colon Polyps (hyperplastic)	☐ Mother ☐ Father ☐ Sister ☐ Brother
☐ Colon Polyps (adenomatous)	☐ Mother ☐ Father ☐ Sister ☐ Brother
☐ Crohn's Disease	☐ Mother ☐ Father ☐ Sister ☐ Brother
☐ Ulcerative Colitis	☐ Mother ☐ Father ☐ Sister ☐ Brother
☐ Celiac Disease	☐ Mother ☐ Father ☐ Sister ☐ Brother
☐ Irritable Bowel Syndrome	☐ Mother ☐ Father ☐ Sister ☐ Brother
☐ Diabetes (☐ type 1 or ☐ type 2)	☐ Mother ☐ Father ☐ Sister ☐ Brother
☐ Chronic Kidney Disease	☐ Mother ☐ Father ☐ Sister ☐ Brother
☐ Other	☐ Mother ☐ Father ☐ Sister ☐ Brother
Explain:	

Patient Medical History

Main reason for today's visit: _____

Other concerns: _____

How would you rate your overall health? (Check the most applicable box): ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please list healthcare providers & their specialty you see regularly:

_____

_____

List any medical equipment you use daily (i.e., CPAP, oxygen, pain pump, feeding tube, etc.):

_____

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MEDICATIONS: Please list (or show us your own printed record) all prescriptions and non-prescription medications. This includes vitamins, herbs, supplements home remedies, birth control pills, inhalers, over the counter pain pills (Advil, Aleve, Tylenol, etc.).

☐ Check this box if you do not take any prescription or over the counter medications.

☐ Check this box if you brought a list of your medications (give to the front counter or nurse and don't write in medications below).

Medication name:	Dose (milligrams, milliliters)	How many times per day?

ALLERGIES: Please check all that apply and list your reaction to the allergen.

Allergy:	Reaction to allergen:	Allergy:	Reaction to allergen:
☐ Acetaminophen (Tylenol)		☐ Latex	
☐ Aspirin		☐ Morphine	
☐ Codeine		☐ Penicillin	
☐ Demerol		☐ Phenergan	
☐ Diprivan		☐ Shellfish	
☐ Hydrocodone		☐ Sulfa	
☐ Iodine		☐ Zofran	
☐ Other:		☐ Other:	
☐ Other:		☐ Other:	
☐ Other:		☐ Other:	
☐ **Patient has no known allergies.**			

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IMMUNIZATIONS: (check all that apply and month & year of vaccination if known)

Immunization:	Month/Year:	Immunization:	Month/Year:
☐ COVID-19	_____/_____	☐ HepatitisA	_____/_____
☐ Tetanus (TD)	_____/_____	☐ Hepatitis B	_____/_____
☐ With Pertussis (Tdap)	_____/_____	☐ MMR	_____/_____
☐ Varicella (Chicken Pox) shot or illness	_____/_____	☐ Meningitis	_____/_____
☐ Pneumovax (pneumonia)	_____/_____	☐ Zostavax (shingles)	_____/_____
☐ Influenza (flu shot)	_____/_____	☐ HPV	_____/_____

RECENT HOSPITAL / FACILITY STAYS:

Have you been to the emergency room in the last 6 months? ☐ No ☐ Yes, what hospital? _____

Have you been admitted to the hospital in the last 6 months? ☐ No ☐ Yes, what hospital? _____

DIAGNOSTIC STUDIES / TESTS: (check all that apply, where it was done, and the date (if known) the study / test was done)

Study / Test:	Facility / Lab / Physician:	Date of Study:
☐ COVID-19		
Where you: ☐ POSITIVE ☐ NEGATIVE Are currently experiencing any symptoms such as fever, cough, etc.? If yes, please explain your symptoms: _____		
☐ Cologuard		
☐ Colonoscopy		
☐ Ultrasound		
☐ CAT Scan / MRI		
☐ EGD (stomach endoscopy)		
☐ ERCP (biliary/pancreatic duct)		
☐ Liver biopsy		
☐ Liver function study		
☐ Blood work		
☐ Other: _____		
☐ Other: _____		

PATIENT HISTORY OF CONDITIONS: Do you have now, or have you had (past) any of the following conditions?

General:			
☐ Does not accept blood products/transfusions	☐ Aspirin long-term use	☐ Blood thinner (other than aspirin)	☐ Defibrillator status
☐ Pacemaker status	☐ Home oxygen # units:	☐ Paraplegic	☐ Quadriplegia
☐ Other:		☐ Other:	
Cardiovascular:			
☐ Abdominal aortic aneurysm	☐ Atrial fibrillation (A Fib)	☐ Congestive heart failure (CHF)	☐ Coronary artery disease
☐ Heart attack	☐ Heart valve disorder	☐ High blood pressure	☐ High cholesterol
☐ Hyperlipidemia	☐ Hypertension	☐ Ischemic heart disease	☐ Peripheral vascular disease
☐ Other:		☐ Other:	
Endocrine:			
☐ Diabetes mellitus Type 1	☐ Diabetes mellitus Type 2	☐ Current use of insulin	☐ Other:
Gastrointestinal:			
☐ Barrets esophagus	☐ Cirrhosis, non-alcoholic	☐ Cirrhosis, alcoholic	☐ Cirrhosis (alcoholic) of liver with ascites

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☐ Colon cancer	☐ Colon polyps (adenomatous)	☐ Colon polyps (hyperplastic)	☐ Crohn's disease
☐ Diverticulitis	☐ Diverticulosis	☐ Fatty liver	☐ Gallstones
☐ Gastric ulcer	☐ Gastroparesis	☐ Gastroesophageal reflux disease (GERD)	☐ Hiatal hernia
☐ Hepatitis A	☐ Hepatitis B	☐ Hepatitis C	☐ Helicobacter pylori (H. pylori) infection
☐ Irritable bowel syndrome (IBS)	☐ Liver cancer	☐ Pancreatitis	☐ Pancreatic cancer
☐ Ulcerative colitis		☐ Other:	
Neurological:			
☐ Seizure disorder	☐ Stroke	☐ TIA (transient ischemic attack, mini stroke)	☐ Other:
Pulmonary:			
☐ Asthma	☐ C.O.P.D.	☐ Emphysema	☐ Arthritis
☐ Lung cancer	☐ Pulmonary embolism	☐ Sleep apnea	☐ Other:
Urinary:			
☐ Bladder cancer	☐ Chronic kidney disease (CKD)	☐ ESRD, on Dialysis	☐ Other:
Other:			
☐ Anemia, iron deficiency	☐ Anemia due to blood loss	☐ Anemia, unspecified	☐ Arthritis
☐ Bipolar disorder (manic depression)	☐ Breast cancer	☐ Elevated liver function test	☐ HIV/AIDS
☐ Depression	☐ Osteoporosis	☐ Ovarian cancer	☐ Prostate cancer
☐ Rheumatoid arthritis	☐ Skin cancer	☐ Uterine cancer	☐ Other:

SURGERY HISTORY: (check all that apply with the year)

Surgical Procedure:	Year:	Physician/Surgeon:	Year:
☐ Abdominal Surgery		☐ Gastric Bypass	
☐ Anal fissurectomy			
☐ Angiogram (heart)		☐ Gastric Sleeve	
☐ Angiogram (vascular)		☐ Heart Surgery Other than coronary bypass checked above: _____	
☐ Appendectomy (appendix removal)		☐ Hernia Repair	
☐ Back surgery (lumbar)		☐ Hip Surgery	
☐ Breast surgery		☐ Hysterectomy (partial, ovaries left)	
☐ CABG (coronary artery bypass graft)		☐ Hysterectomy (total, including ovaries)	
☐ Cardiac Valve Replacement (heart valve)		☐ LEEP (cervix surgery)	
☐ Colon Resection		☐ Neck Surgery (spine)	
☐ Coronary Bypass (heart bypass)		☐ Ovary Removal	
☐ Coronary Stent (stent in heart)		☐ Pacemaker	
☐ C-Section		☐ Pulmonary Function Test	
☐ Echocardiogram (heart)		☐ Sinus Surgery	
☐ Gallbladder Removal		☐ Tonsillectomy	
☐ Gastric Banding		☐ Tubal Ligation	
☐ Other:			
☐ Other:			
☐ Other:			
☐ Other:			

NGA NORTHLAKE GASTROENTEROLOGY ASSOCIATES

Physicians:
Gregory Mula, M.D. • Lawrence Gensler, M.D. • Dennis Booth, Jr. M.D. •
Jason Reina, M.D. • Russell Wardlaw, M.D.

Nurse Practitioners:
Wendy Peterson, NP • Alisa Picou, NP • Wendi Neal, NP •
Whitney Morgan, FNP-C • Alexandra Morgan, FNP-c

REVIEW OF SYSTEMS: Have you had any of the following symptoms (diagnostic) in the last 60 days?

ALLERGIC/IMMUNOLOGIC:	**EYES:**	**INTEGUMENTARY:**
☐ HIV exposure	☐ Double vision	☐ Itching
☐ Persistent infections	☐ Loss of vision	☐ Jaundice
☐ Strong allergic reactions to urticaria	☐ Photophobia	☐ Rashes
☐ NONE	☐ Eye trauma	☐ NONE
CARDIOVASCULAR:	☐ NONE	**MUSCULOSKELETAL:**
☐ Chest pain	**GASTROINTESTINAL:**	☐ Back pain
☐ Dyspnea with exercise	☐ Abdominal pain	☐ Joint pain
☐ Irregular heartbeat	☐ Abdominal swelling	☐ Muscle weakness
☐ Orthopnea	☐ Change in bowel habits	☐ NONE
☐ Palpitations	☐ Constipation	**NEUROLOGICAL:**
☐ Peripheral edema	☐ Diarrhea	☐ Dizziness
☐ Syncope	☐ Gas	☐ Fainting
☐ NONE	☐ Heartburn	☐ Frequent headaches
CONSTITUTIONAL:	☐ Jaundice	☐ Migraine
☐ Fatigue	☐ Nausea	☐ Numbness or tingling
☐ Fever	☐ Rectal bleeding	☐ Seizures
☐ Loss of Appetite	☐ Stomach cramps	☐ Tremors
☐ Malaise	☐ Vomiting	☐ Vertigo
☐ Sweats	☐ Difficulty swallowing	☐ Memory Loss
☐ Weight gain	☐ NONE	☐ NONE
☐ Weight loss	**GENITOURINARY:**	**PSYCHIATRIC:**
☐ NONE	☐ Dark urine	☐ Anxiety
ENMT:	☐ Decrease in urine flow	☐ Depression
☐ Difficulty swallowing	☐ Dysuria	☐ Difficulty sleeping
☐ Dizziness	☐ Frequent urinary infections	☐ Hallucinations
☐ Ear pain	☐ Frequent urination	☐ Nervousness
☐ Nasal obstruction	☐ Hematuria	☐ Panic attacks
☐ Nosebleeds	☐ Impotence	☐ NONE
☐ Sore throat	☐ Nocturia	**RESPIRATORY:**
☐ Hearing loss	☐ Urethral discharge or incontinence	☐ Asthma
☐ Snoring	☐ NONE	☐ Cough
☐ NONE	**HEMATOLOGIC/LYMPHATIC:**	☐ Dyspnea
ENDOCRINE:	☐ Bleeding gums	☐ Excessive sputum
☐ Excessive thirst	☐ Palpable lymph nodes	☐ Coughing up blood
☐ Hair loss	☐ Easy bruising	☐ Shortness of breath
☐ Heat intolerance	☐ Prolonged bleeding	☐ Wheezing
☐ NONE	☐ NONE	☐ NONE

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TOBACCO USE:

Do you or have you smoked tobacco? ☐ NO ☐ Cigarettes ☐ Cigars ☐ Pipe

If YES, how often do you / have you smoked tobacco?

☐ Current smoker: Packs per day: _____ # of years: _____

☐ Former smoker: Quit Date: _____/_____/_____

- Approximately how many packs/day did you smoke?_____
- How many years did you smoke? _____

Other tobacco? ☐ Snuff ☐ Chewing ☐ Vaping

CAFFEINE USE:

Do you consume caffeinated beverages or supplements?

☐ Coffee ☐ Tea ☐ Cola ☐ Energy drinks/shots

☐ Other: _____

ALCOHOL USE:

Do you drink alcohol? ☐ Yes ☐ No

# of drinks /week: _____ ☐ Beer ☐ Wine ☐ Liquor

DRUG USE:

Have you ever used recreational drugs? ☐ Yes ☐ No

If yes, which ones? _____

Any IV drug use: ☐ Yes ☐ No

If yes, which ones? _____

SEXUAL ACTIVITY:

Are you sexually involved? ☐ Not currently ☐ Never ☐ Yes

Birth control method or STD prevention (check all that apply):

☐ None needed ☐ Condom ☐ Pill ☐ IUD ☐ Patch
☐ Tubal Ligation ☐ Diaphragm ☐ Vasectomy ☐ Ring

☐ Other: _____

ADDITIONAL INFO:

Military Service? ☐ Yes ☐ No
Blood Transfusion? ☐ Yes ☐ No
Exposure to toxic chemicals at work? ☐ Yes ☐ No
Exposure to toxic chemicals doing hobbies? ☐ Yes ☐ No

DIET:

Do you follow a special diet? ☐ Yes ☐ No

☐ Low carb ☐ High protein ☐ Ketogenic
☐ Gluten-free ☐ Dairy Free ☐ Vegetarian ☐ Vegan
☐ Other: _____

EXERCISE:

Do you exercise regularly? ☐ Yes ☐ No

If yes, what kind of exercise?

_____

_____

How long (minutes)? _____ How often? _____

Consent to Import Medication History

☐Yes ☐No I consent to obtaining a history of my medications purchased at pharmacies.

Consent to Share Data

☐Yes ☐No I consent to having my medical and demographic information shared with other healthcare entities.

Name (print): _____ **Date of Birth: _____/_____/_____**

Signature: _____ **Today's Date: _____/_____/_____**