GASTROENTEROLOGY PRACTICE ASSOCIATES ⅋ PATIENT REGISTRATION

Please Print Clearly

Patient's Name:____ **SS #:** ______________________
First Name Middle Name Last Name

Date of Birth:______________ □ Male □ Female □ Single □ Married □ Widowed □ Divorced □ Separated

Street Address:________________________________ **Email:** ________________________________

City/State/Zip Code:____________________________ **Home Phone w/Area Code:(**)________-________

Cell Phone w/Area Code:( )________-__________ **Work Phone w/ Area Code:(**)________-________

Race: **☐American Indian or Alaska Native ☐Asian ☐Black/African American ☐Hispanic/Latino**
☐Native Hawaiian or Other Pacific Islander ☐White/Caucasian ☐Other ☐Unknown ☐Patient declines to provide information

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Patient declines to provide information

Patient's Employer: ____________________**Check One: ☐FT ☐ PT ☐ NOT EMPLOYED ☐ DISABLED ☐ RETIRED ☐ STUDENT**

In case of emergency, contact name:____

PhoneNumber w/Area Code:(**)**______-__________ **Relationship to Patient:**________________________

Referring Physician's Name: ____________________________ Phone: ____________________________

Primary Care Physician Name: ______________________ **☐Same** Phone: ____________________________

PLEASE PRESENT INSURANCE CARD(S) & PHOTO ID FOR COPYING AND COMPLETE THE REQUESTED INFORMATION

------------- PLEASE NOTE: YOUR <u>SPECIALIST</u> CO-PAY WILL BE DUE UPON CHECK-IN FOR APPOINTMENT -----------------

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Primary Insurance Name:____

>><u>Primary Insured's Name</u>:____________________________ **>><u>Date of Birth</u>:**____________________

Primary Insured's Social Security#: ______________________ **Relationship:**____________________

Policy #:____________________**Group #:**________________________

Secondary Insurance Name:____

>><u>Primary Insured's Name</u>:____________________________ **>><u>Date of Birth</u>:**____________________

Primary Insured's Social Security#: ______________________ **Relationship:**____________________

Policy #:____________________ **Group #:**________________________

- **I hereby authorize the payment of medical benefits to Gastroenterology Practice Associates for services rendered. I understand that I am financially responsible for any services not covered by my insurance carrier.**
- **I further agree to pay all collections costs, attorney fees, and other collections costs that may be incurred to enforce the collection of any amounts outstanding.**
- **I hereby authorize Gastroenterology Practice Associates to release any medical information necessary to complete and process my insurance claims.**
- **I hereby authorize Gastroenterology Practice Associates to treat me and use my personal health information for healthcare operations**

>>____ ____________________
>>*Patient's OR Insured's Signature* (If patient is a Minor, must have Responsible Party Signature) Date

GASTROENTEROLOGY PRACTICE ASSOCIATES ꟾ HEALTH HISTORY

MEDICAL HISTORY / CONDITIONS (Check all that apply)

☐ Acid Reflux Disease/GERD
☐ AIDS / HIV Positive (Circle)
☐ Anemia (Diagnosed by a physician)
☐ Arthritis / Osteoarthritis (Circle)
☐ Asthma
☐ Barrett's Esophagus
☐ Cancer (What Type) ___________
☐ Celiac Disease
☐ Chemical Dependency
☐ Crohn's Disease
☐ Diabetes – Type I or Type II (Circle)
☐ Diverticulitis / Diverticulosis (Circle)
☐ Emphysema
☐ Epilepsy / Seizures (Circle)
☐ Fatty Liver
☐ Heart Disease:
Cardiologist________________
☐ Hemorrhoids
☐ Hepatitis A / B / C (Circle)
☐ High Blood Pressure
☐ High Cholesterol
☐ History of Colon Polyps
☐ History of H. Pylori Infection
☐ Irritable Bowel Syndrome
☐ Kidney Disease
☐ Liver Cirrhosis
☐ Multiple Sclerosis
☐ Osteoporosis
☐ Pacemaker
☐ Prostate Disease
☐ Psychiatric Care
☐ Sleep Apnea
☐ Stomach Ulcers
☐ Stroke / Heart Attack (Circle)
☐ Thyroid Disease –
Overactive / Underactive (Circle)
☐ Ulcerative Colitis
☐ **Other**: ___________________

PAST SURGICAL HISTORY

(list all surgeries / procedures you have had and the **year**)

1. ______________________Yr _______ 6. ________________________ Yr _______
2. ______________________Yr _______ 7. ________________________ Yr _______
3. ______________________Yr _______ 8. ________________________ Yr _______
4. ______________________Yr _______ 9. _________________________Yr _______
5. ______________________Yr _______ 10. _________________________Yr _______

Date of Last Upper Endoscopy: _______________ **Performing Dr.** ___________________
Date of Last Colonoscopy: ____________________ **Performing Dr.** ___________________

Polyps Removed? ☐YES ☐NO

CURRENT MEDICATIONS WITH DOSAGE

1. ____________________MG _________ 6. _____________________MG__________
2. ____________________MG_________ 7. _____________________MG__________
3. ____________________MG_________ 8. _____________________MG__________
4. ____________________MG_________ 9. _____________________MG__________
5. ____________________MG_________ 10. ____________________MG__________

DRUG ALLERGIES

_____________________________ _____________________________
_____________________________ _____________________________

PAST HOSPITALIZATIONS **REASON** AND THE **YEAR**

_____________________________YR ________ _____________________________YR______
_____________________________YR________ _____________________________YR______

FAMILY HISTORY

List any known illnesses, cancers or conditions

Mother: ____ ☐Alive ☐ Deceased
Father: ____ ☐Alive ☐ Deceased
Siblings: ____ ☐Alive ☐ Deceased
Maternal GM: ____ ☐Alive ☐ Deceased
Maternal GF: ____ ☐Alive ☐ Deceased
Paternal GM: ____ ☐Alive ☐ Deceased
Paternal GF: ____ ☐Alive ☐ Deceased

PLEASE LIST YOUR PREFERRED PHARMACY (this will be listed on your chart for any new prescriptions given)

Pharmacy Name: ______________________________ Med Co ID#:__________________
Address / Cross Streets:
____
PhoneNumber: ____

GASTROENTEROLOGY PRACTICE ASSOCIATES ఐSYMPTOM SURVEY

Instructions: Please check YES to symptoms you are currently experiencing and NO to symptoms you are not feeling today or within the past week.

NEUROLOGICAL

□ Yes □ No Fatigue (sluggish, tired)
□ Yes □ No Restlessness at Night
□ Yes □ No Seizures

EMOTIONAL/MENTAL

□ Yes □ No Depression
□ Yes □ No Anxiety
□ Yes □ No Mood Swings
□ Yes □ No Lack of Concentration/Focus
□ Yes □ No Stress

HEAD/EARS/EYES

□ Yes □ No Headaches (any kind)
□ Yes □ No Decreased Hearing
□ Yes □ No Glaucoma

NASAL/SINUS

□ Yes □ No Post Nasal Drip
□ Yes □ No Sinus Pain
□ Yes □ No Stuffy Nose

MOUTH/THROAT

□ Yes □ No Sore Throat
□ Yes □ No Swollen Throat
□ Yes □ No Swelling of Lips/Tongue
□ Yes □ No Gagging / Choking
□ Yes □ No Lesions ("Canker Sores")
□ Yes □ No Difficulty Swallowing
□ Yes □ No Painful Swallowing
□ Yes □ No Chronic Belching

LUNGS

□ Yes □ No Wheezing
□ Yes □ No Chest Congestion
□ Yes □ No Non-Productive Coughing
□ Yes □ No Productive Coughing

GENITOURINARY

□ Yes □ No Increased Urinary Frequency
□ Yes □ No Painful Urination
□ Yes □ No Blood in Urine
□ Yes □ No Lack of Bladder Control

MUSCULOSKELETAL

□ Yes □ No Joint Pains/Aching
□ Yes □ No Muscle Aches

GASTROINTESTINAL

□ Yes □ No Heartburn/Indigestion
□ Yes □ No Abdominal Pain
□ Yes □ No Constipation
□ Yes □ No Diarrhea
□ Yes □ No Bloating Sensation
□ Yes □ No Excessive Flatulence
□ Yes □ No Nausea
□ Yes □ No Vomiting
□ Yes □ No Painful Elimination
□ Yes □ No Poor Appetite
□ Yes □ No Chills
□ Yes □ No Fever
□ Yes □ No Fecal Incontinence
□ Yes □ No Black/Tarry Stools
□ Yes □ No Change in Bowel Pattern
□ Yes □ No Blood in Stool
□ Yes □ No Rectal Pain/Pressure

WEIGHT MANAGEMENT

□ Yes □ No Binge Eating
□ Yes □ No Purging (all methods)
□ Yes □ No Excessive Weight Loss
□ Yes □ No Weight Gain

SOCIAL HISTORY, PART I

□ Yes □ No Do you smoke?
If Yes, How many packs per day?________
How many years?_________
If Quit, When? ____________

□ Yes □ No Have you ever traveled outside the US within the past year?
If Yes, Where? ______________________
____

SOCIAL HISTORY , PART II

□ Yes □ No Do you drink alcohol?
If Yes, What Type? Liquor Beer Wine
How Often? ________________
How Many Glasses Per Occasion?_______

□ Yes □ No Have you ever had a blood transfusion?
If yes, When? _______________________

□ Yes □ No Do you have history of Drug Use?

SOCIAL HISTORY , PART III

□ Yes □ No Do you drink caffeine?
If Yes, What Type?

TEA COFFEE SODA

How many cups per day? Please Circle
1 2 3 4 5 >5

GASTROENTEROLOGY PRACTICE ASSOCIATES ꩜BILLING POLICY

- I understand that it is my responsibility to provide our office with current, accurate billing information at the time of check in and to notify us of any changes in this information.
- **I understand that it is my responsibility to know my specialist co-pay**(which can be different than my Primary Care co-payment) and to pay it at the time services are being rendered. I understand that this is a contractual agreement that I have with my health plan and that the clinic also has a contractual agreement with my health plan to collect co-pays at the time of service, and they are required to report to the carrier any enrollees failing to pay the co-pay.
- I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged a $35 NSF fee. I further understand that to rectify my account, I will be required to pay with cash, a money order, cashier's check, or credit card.
- I understand that there is a $20 fee to complete disability paperwork associated with my care. I will be provided a standard form free of charge; however if additional disability forms (such as FMLA) require completion, I understand that the $20 fee (payable prior to completion) is required.
- I understand that I will be billed for any amounts due by me (co-payments/coinsurance amounts/ deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with three (3) statements for any balance due after insurance payment. I further understand that if I have not made payment prior to the second statement being mailed, that the third statement will be marked as "Final Notice" and will be sent to an outside collection service if I do not fulfill my financial obligations. **I understand that if my account is turned over to a collection agency a $75 service charge will be added to the balance.**
- I understand that the clinic will obtain the necessary prior authorizations prior to rendering treatment. I further understand that prior authorization is not a guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier.

HIPAA Privacy Practices

(A copy of the HIPAA Practices is located at the front desk, If you would like a copy to keep please ask the receptionist)

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices of Gastroenterology Practice Associates, PLLC*. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information and your rights related to the Use and Disclosure of your protected health information. We encourage you to read it in full.

Our *Notice of Privacy Practices* is subject to change. If we change our notice, a notice will be posted in the office and on our website, you may obtain a copy of the revised notice by: Asking the staff at the reception desk in the office or by *requesting a copy from our office at Gastroenterology Practice Associates, PLLC at 301 Highlander Blvd. Ste 121, Arlington, TX 76018, or calling 817-468-7200.*

If you have any questions about our *Notice of Privacy Practices*, please contact:
Privacy Officer, Gastroenterology Practice Associates, PLLC at 301 Highlander Blvd. Ste 121, Arlington, TX 76018
Or calling 817-468-7200

I acknowledge receipt of the *Notice of Privacy Practices* of *Gastroenterology Practice Associates, PLLC.*

Print Name: ________________________________ Relation to Patient: ___________________________

Signature: ________________________________ Date: ______________________________________

(Staff) Witness Name: _______________________

(Staff) Witness Signature: ____________________ Date: ______________________________________

Gastroenterology Practice Associates∞Family Medical Release Form

As a patient of Gastroenterology Practice Associates, I understand that there may be occasions where the office staff may need to contact me regarding appointments, the scheduling of tests, test results, medications, etc. In such event, I am unavailable; I authorize Gastroenterology Practice Associates to discuss my medical record (including test results and plan of care) with the following individuals. This authorization also includes the leaving of voicemail messages on my home, work, and/or cell phone. I give Gastroenterology Practice Associates permission to discuss my personal health information as stated above with the following individuals:

Name ________________________ Relationship ______________ Phone ____________________

Name ________________________ Relationship ______________ Phone ____________________

Name ________________________ Relationship ______________ Phone ____________________

Name ________________________ Relationship ______________ Phone ____________________

☐Check this box if you do not have anyone that you would like us to release your medical information too.

___________________________________ ______________________

Patient Signature Date

I understand that I may revoke this authorization at any time by notifying the office ***in writing*** *of my desire to do so.*