

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 African American Native Hawaiian or Other Pacific Islander
 White/Caucasian Other Unknown Patient declines to provide

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

PLEASE LIST YOUR PREFERRED PHARMACY

Pharmacy Name: _____ Address / Cross Streets: _____

Phone Number: _____

In case of emergency, contact name: _____

Phone Number w/Area Code:() _____ - _____ Relationship to Patient: _____

Referring Physician's Name: _____ Phone: _____

Primary Care Physician Name: _____ Same Phone: _____

Do you have an advanced directive or living will? Please Circle: Yes or No

PLEASE PROVIDE INSURANCE INFORMATION BELOW

Primary Insurance Name: _____

>>Primary Insured's Name: _____ >>Date of Birth: _____

Primary Insured's Social Security#: _____ Relationship: _____

Policy #: _____ Group #: _____

Secondary Insurance Name: _____

>>Primary Insured's Name: _____ >>Date of Birth: _____

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

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

GASTROENTEROLOGY PRACTICE ASSOCIATES 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 _____ | 9. _____ MG _____ |
| 2. _____ MG _____ | 10. _____ MG _____ |
| 3. _____ MG _____ | 11. _____ MG _____ |
| 4. _____ MG _____ | 12. _____ MG _____ |
| 5. _____ MG _____ | 13. _____ MG _____ |
| 6. _____ MG _____ | 14. _____ MG _____ |
| 7. _____ MG _____ | 15. _____ MG _____ |
| 8. _____ MG _____ | 16. _____ MG _____ |

DRUG ALLERGIES

PAST HOSPITALIZATIONS REASON AND THE YEAR

_____ YR _____ YR _____
_____ YR _____ YR _____

FAMILY HISTORY

(Do not list family member names)

List any known illnesses, cancers or conditions

Mother: _____	<input type="checkbox"/> Alive	<input type="checkbox"/> Deceased
Father: _____	<input type="checkbox"/> Alive	<input type="checkbox"/> Deceased
Siblings: _____	<input type="checkbox"/> Alive	<input type="checkbox"/> Deceased
Maternal GM: _____	<input type="checkbox"/> Alive	<input type="checkbox"/> Deceased
Maternal GF: _____	<input type="checkbox"/> Alive	<input type="checkbox"/> Deceased
Paternal GM: _____	<input type="checkbox"/> Alive	<input type="checkbox"/> Deceased
Paternal GF: _____	<input type="checkbox"/> Alive	<input type="checkbox"/> Deceased

GASTROENTEROLOGY PRACTICE ASSOCIATES SYMPTOM 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

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? _____

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

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?

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 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.*