PLEASE COMPLETE PRIOR TO VISIT***Place your name at the bottom of each sheet

GASTROINTESTINAL ASSOCIATES, INC.
PATIENT REGISTRATION

Welcome to our practice. Please complete all sections of this registration form. Thank you.

Patient Information

Last Name_____First_____MI_____

Address_____Apt.#_____

City_____ State_____ Zip Code_____

Sex: M F Marital Status: Single Married Other Student: FT PT

Employed By_____

Email Address_____Cell Phone#_____

Home Phone#_____WorkPhone#_____

Emergency Contact Name_____Relation_____Phone_____
(Other than numbers listed above)

Date of Birth_____

Federal Government Requirement: Race_____ Language Spoken_____

Ethnicity: Circle: Hispanic or Latino Non-Hispanic or Non-Latino

Pharmacy Name, Address, Phone#, Fax#:_____

_____

Mail Order Pharmacy Name, Address, Phone#, Fax#:_____

_____

PLEASE BRING ALL MEDICINE BOTTLES TO YOUR APPOINTMENT

Referral Information

Primary Care Physician_____

Address_____Telephone#_____

Insurance Company Information

Patient's Relationship to Insured Party (Circle One): Self Child Wife Husband Other

Primary Insurance Co._____

Secondary Insurance Co._____

I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE THIS INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION, HEALTH CARE FINANCING ADMINISTRATION, MY INSURANCE COMPANY OR ITS INTERMEDIARIES OR CARRIERS, OR TO THIS PHYSICIAN'S OFFICE OR TO MY ATTORNEY OR OTHER DOCTOR'S OFFICE.

I AUTHORIZE DIRECT PAYMENT OF MEDICAL BENEFITS AND/OR SURGICAL BENEFITS, TO INCLUDE MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITLED, INCLUDING MEDICARE, PRIVATE INSURANCE, AND ANY OTHER HEALTH PLAN TO GASTROINTESTINAL ASSOCIATES, INC. I ALSO PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE.

DATE_____SIGNATURE_____

(3/13)

Name:

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HISTORY FORM

NAME: _____ TODAY'S DATE: _____

Required!

***Reason for appointment*: _____ Date of Birth: _____**

1. **Please list any medications (prescriptions, over-the-counter, herbals, vitamins, etc.) you are currently taking. Include the amount and how often:**
2. **Also, please bring all medication bottles to your appointment.**

Pharmacy: Name:_____ Address:_____

Phone number:_____ Fax number: _____

Mail Order Pharmacy: Name: _____

Address: _____

Phone number: _____ Fax Number: _____

Past or Present Medical Problems

O Anemia	O Depression	O Heart Attack	O Liver Cancer	O Stroke or TIA
O Anxiety disorder	O Diabetes	O Hepatitis A	O Liver Disease	O Thyroid Disease
O Arthritis	O Diverticulitis	O Hepatitis B	O Lung Cancer	O Ulcer
O Asthma	O Diverticulosis	O Hepatitis C	O Pacemaker	O Ulcerative Colitis
O Breast Cancer	O Emphysema	O Hepatitis, Other	O Pancreatitis	O **NONE**
O Celiac Sprue	O Esophageal Cancer	O High Blood Pressure	O Prostate Cancer	
O Colon Cancer	O Gallstones	O Irritable Bowel Syndrome	O Reflux	
O Crohn's Disease	O Glaucoma	O Kidney Disease	O Sexually Transmitted Disease	
O Defibrillator	O Gynecologic Cancer	O Kidney Stones	O Sleep Apnea	

Allergies:

Substance:	**Reaction:**

Name:

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Surgeries/procedures/Hospitalizations

O	Appendix Removal	O	Heart Surgery	O	Blood Transfusion	O	ERCP
O	Colon Surgery	O	Hysterectomy	O	Bravo Capsule	O	Esophageal Manometry
O	Cardiac stent	O	Joint Surgery	O	Capsule Endoscopy	O	Liver Biopsy
O	Gallbladder Surgery	O	Prostate Surgery	O	Colonoscopy/ *When?*	O	Flexible Sigmoidoscopy
O	Gastric Bypass/ Obesity Surgery			O	Endoscopy/ *When?*		

o **None**

FAMILY HISTORY:

	Father	Mother	Siblings	Grandmother*	Grandfather*
Colon Cancer	**O**	**O**	**O**	**O**	**O**
age at diagnosis	____	____	____	____	____
Colon Polyps	**O**	**O**	**O**	**O**	**O**
Crohn's Disease/ Ulcerative Colitis	**O**	**O**	**O**	**O**	**O**
Esophageal Cancer	**O**	**O**	**O**	**O**	**O**
Gastric Cancer	**O**	**O**	**O**	**O**	**O**
Liver Disease	**O**	**O**	**O**	**O**	**O**
Pancreatic Cancer	**O**	**O**	**O**	**O**	**O**
Other	____	____	____	____	____

***Please note maternal (M) or paternal (P)**

Social History:

Social History/Marital Status:

O Single O Separated O Married
O Divorced O Widowed O Other

Social History/Recreational Drugs:

O I have never used recreational drugs
O I have used recreational drugs

Social History/Alcohol:

Have you had a drink containing alcohol in the past year?
O Yes
How often?

How many?
O No

Social History/Tobacco: Are you a:

O Current smoker?
How many in a day?

O Nonsmoker?

O Former smoker?-*How long ago?*

Social History/Occupation:

Patient Occupation_____

Name:

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ARE YOU <u>NOW</u> EXPERIENCING?

Gastrointestinal:

O Abdominal pain	O Blood in Stool/Black stools	O Gas	O Milk Intolerance	O Difficulty Swallowing
O Belching	O Change in Bowel Habits	O Heartburn/GERD	O Loss of Appetite	O Vomiting
O Black Stool	O Constipation	O Incontinence to Stool	O Nausea	O **NONE**
O Bloating	O Diarrhea	O Jaundice	O Pain with Bowel Movement	

Genitourinary:

O Blood in urine

O Difficulty with Urination

O Change in urinary frequency

O **NONE**

Skin:

O Itching

O **NONE**

O Rashes

Cardiovascular:

O Angina/Chest Pressure

O Irregular Heart Beat

O **NONE**

Respiratory:

O Cough

O Shortness of Breath

With or without exertion?

O **NONE**

Neurological:

O Headaches

O Seizures

O **NONE**

Endocrine:

O Excessive thirst

O Excessive Urination

O Hair Change

O **NONE**

Constitutional:

O Fever

O Weight Loss

O Intentional O Unintentional

How much weight lost:

Over what period of time?

O **NONE**

Psychiatric:

O Anxiety

O Depression

O **NONE**

Eyes (Ophthalmologic):

O Change in Vision

O Eye Pain

O **NONE**

Hematologic:

O Prolonged Bleeding

O Enlarged Gland

O **NONE**

Name:

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Ears, Nose and Throat:

O Hoarseness

O Mouth Sores

O **NONE**

Musculoskeletal:

O Joint Pain

O Swollen Joints

O **NONE**

Immunizations (such as flu shots, Hepatitis A, Hepatitis B) and when you had these:

*It is important that you complete this form and bring it with you to your appointment. If you have access to a fax machine and would like to fax it in advance you can fax to:

215-348-3780 for the Doylestown office
267-620-1188 for the Rydal office

Please bring the original with you in case the faxed copy is less than ideal.

***In order to make sure that any prescriptions ordered for you go to the correct pharmacy it is important that you complete the section where you list your pharmacy. There are many pharmacies with the same name and similar addresses so please make sure that you provide all of the requested information.*

Thank you!!

Name:

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Read before signing the Acknowledgement and Consent.

This acknowledgement of notice and consent authorizes Gastrointestinal Associates to use and disclose health information about you for treatment, payment, health care operation purposes and prescription history.

Notice of Privacy Practices. Gastrointestinal Associates has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgement and consent.

Amendments. We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our privacy officer.

How To Contact Our Privacy Officer

Mail: Gastrointestinal Associates, 1095 Rydal Road, Suite 100, Rydal, PA 19046, ATTN: Privacy Officer.
Telephone: 267-620-1100 Ask for Privacy Officer.
Facsimile: 215-947-4316.

Acknowledgement and Consent

I have been given the opportunity to receive the Notice of Privacy Practices for Gastrointestinal Associates. Gastrointestinal Associates is authorized to use and disclose health information about _____(patient name) for treatment, payment and healthcare operations purposes consistent with its Notice of Privacy Practices.

_____ _____
Signature of patient or personal representative Date

Personal representative information (if applicable):

_____ _____
Name of personal representative Relationship to patient (or authority)

(Acknowledgement 11/12)

Name: