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#_____

Date of Birth_____

Emergency Contact Name_____Relation_____Phone_____
(Other than numbers listed above)

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#:_____

_____

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._____**ID#**_____

Secondary Insurance Co._____**ID#**_____

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_____
(5/16)

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

HISTORY FORM-Gastrointestinal Associates, Inc.

NAME: _____ TODAY'S DATE: _____

Required!

Reason for appointment: _____ Date of Birth: _____

1. Please list any medications (prescriptions/over the counter drugs/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-check those that apply:

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 Other
O Celiac sprue	O Esophageal cancer	O High blood pressure	O Prostate cancer	**describe
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:

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

Surgeries/procedures/hospitalizations-check those that apply:

O Appendix removal	O Heart valve surgery	O ERCP	O Esophageal manometry
O Colon surgery	O Hysterectomy	O Liver biopsy	O Bravo capsule or 24 hour pH study
O Cardiac stent or bypass	O Joint replacement	O Capsule endoscopy	O Organ transplant
O Gallbladder surgery	O Prostate surgery	O Colonoscopy/*When?*	O Flexible sigmoidoscopy
O Endoscopy/*When?*	O Other ***describe	O **None**	O Gastric bypass/obesity surgery

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
Stomach cancer	O	O	O	O	O
Liver disease	O	O	O	O	O
Pancreatic cancer	O	O	O	O	O
Diabetes	O	O	O	O	O
Heart disease	O	O	O	O	O
High blood pressure	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/Alcohol:

Have you had a drink containing alcohol in the Past year?

O Yes-*How often?*

How many?

O No

Social History/Recreational Drugs:

O I have never used recreational drugs

OI have used recreational drugs

Social History/Tobacco are you:

O Current smoker O Nonsmoker

How many in a day?

O Former smoker-*How long ago?*

Social History/Occupation:

Patient Occupation: _____

Name:_____

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

ARE YOU NOW EXPERIENCING?

Gastrointestinal:

O Abdominal pain
O Belching
O Black stool
O Bloating
O Blood in stool
O Change in bowel habits
O Constipation
O Diarrhea
O Gas
O Heartburn/GERD
O Incontinence to stool
O Jaundice
O Milk intolerance
O Loss of appetite
O Nausea
O Painful bowel movement
O Difficulty swallowing
O Vomiting
O **NONE**

Genitourinary:

O Blood in urine
O Change in urinary frequency
O **NONE**

Skin:

O Itching
O Rashes
O **NONE**

Cardiovascular:

O Angina/chest pressure
O Irregular heart beat

O **NONE**

Cardiologist Name & Phone#if Applicable:

_____

_____

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 loss?

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**

Ear, 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, pneumonia, shingles) and when you had these:

Immunization	Date

*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:

Chalfont office 215-348-3780
Rydal office 267-620-1188

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

**In order to make sure that all 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.

***Please make sure to get copies of any recent lab work or x-ray tests that may be helpful to the doctor you will be seeing.

Thank you!

GASTROINTESTINAL
ASSOCIATES, Inc.
Practice Limited to Gastroenterology

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)

_____

Signature of patient if under 18 years of age

Jefferson University Physicians

GASTROINTESTINAL ASSOCIATES, Inc.

Practice Limited to Gastroenterology

JUP PATIENT SIGNATURE ON FILE FORM

Patient Name: _____ Date of Birth: _____
(Please Print)

IDX Account #: _____

Medicare

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Jefferson University Physicians and/or to the individual Attending Physician, for any services furnished to me by that Physician. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to myself or the party who accepts assignment.

In order to comply with Medicare regulations, please answer the following questions:

- Are you or your spouse employed? ☐ Y ☐ N
- Do you or your spouse have other insurance? ☐ Y ☐ N
- Are you disabled or have end stage renal disease? ☐ Y ☐ N
- Is illness/injury the result of an auto accident? ☐ Y ☐ N
- Did illness/injury occur at work? ☐ Y ☐ N
- Has treatment been authorized by the V.A.? ☐ Y ☐ N
- Are you covered under the Black Lung Program? ☐ Y ☐ N
- Is there Medigap coverage secondary to Medicare? ☐ Y ☐ N
- Is there insurance coverage primary to Medicare? ☐ Y ☐ N
- Is there employer supplemental coverage secondary to Medicare? ☐ Y ☐ N

Medigap (Medicare Secondary Insurance)

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Jefferson University Physicians for any services furnished to me by that physician. I authorize any holder of Medicare information about me to release to my Medigap Coverage any information needed to determine these benefits payable for related services.

Pennsylvania Medical Assistance

I understand that payment for service(s) or items received will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of material may be prosecuted under applicable Federal and State laws.

Commercial

Assignment of Insurance Benefits

I hereby authorize payment directly to Jefferson University Physicians for medical benefits including any Major Medical benefits otherwise payable to me under the terms of my policy but not to exceed the balance due to the physicians. In making this agreement, I understand and agree that I am financially responsible to the above party for charges not paid under this insurance policy. I permit a copy of this authorization to be used in place of the original.

General

Release of Information

I hereby authorize Jefferson University Physicians to disclose to my insurance company(s) copies of my medical records(s) to obtain payment for services or as part of a payment review of medical services, or in the case of Workers Compensation claims, to my present or past employer(s). Additionally, I authorize Jefferson University Physicians to release copies of my medical record(s) to other health care providers serving as consultants to my physician, including referrals for treatment. I recognize that the information disclosed may be protected by federal and/or state law, and I specifically consent to disclose of such information. I understand that this authorization may be revoked at any time, except to the extent that action has been taken in reliance upon it.

Use of Photograph

The undersigned agrees that any patient photographs taken in connection with medical treatment will be considered a part of the patient's medical record and may be used by the patient's health care provider solely for purposes of patient identification.

Financial Agreement

In consideration of the services rendered to the below named patient, the undersigned agrees to pay Jefferson University Physicians in accordance with its regular charges and terms and, if this account is referred to an attorney or agency for collection, to pay attorney(s) fees, court costs, and collection expenses. I also agree to be responsible for charges not covered by insurance. I understand that my obligation to pay Jefferson University Physicians may not be deferred for any reason, including pending legal action against other parties, to recover medical costs.

The undersigned certifies that each has read and understands the above terms and conditions.

❯ _____ _____
Patient Signature Date

❯ _____ _____
Patient's Agent Representative and Guarantor Signature Date