

**GASTROENTEROLOGY ASSOCIATES OF COLUMBUS, PA/  
COLUMBUS ENDOSCOPY CENTER, INC.  
PATIENT INFORMATION SHEET**

Referred By: \_\_\_\_\_ Date: \_\_\_\_\_

Primary Doctor: \_\_\_\_\_ Chart #: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Physical Address (if different): \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

\*\*\***Email:** \_\_\_\_\_ *This will be used for patient portal registration\*\*\**

Date of Birth: \_\_\_\_\_ Patient's Sex: M \_\_\_\_\_ F \_\_\_\_\_ Age: \_\_\_\_\_

Patient's Employer: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Spouse or Parents' Name: \_\_\_\_\_ Spouse or Parents' Social Security #: \_\_\_\_\_

Spouse or Parents' Date of Birth: \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_ Age: \_\_\_\_\_

Spouse or Parent's Employer: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Location: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Have you seen our commercial featuring Dak Prescott? Yes \_\_\_\_\_ No \_\_\_\_\_**

**Primary Insurance:** \_\_\_\_\_ Phone #: \_\_\_\_\_

Policy Holder (Name of Insured): \_\_\_\_\_ Insured DOB: \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_

Policy Holder Social Security #: \_\_\_\_\_ I. D. #: \_\_\_\_\_ Group #: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ Phone #: \_\_\_\_\_

Policy Holder (Name of Insured): \_\_\_\_\_ Insured DOB: \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_

Policy Holder Social Security #: \_\_\_\_\_ I. D. #: \_\_\_\_\_ Group #: \_\_\_\_\_

**Do you have a medical savings plan, flexible spending plan, or gap plan through your employment which assists with payment of medical services? Yes \_\_\_\_\_ No \_\_\_\_\_**

Patient's Full Name Printed: \_\_\_\_\_ SS#: \_\_\_\_\_ Chart #: \_\_\_\_\_

**ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY:** I authorize all insurance payments to be paid to Gastroenterology Associates of Columbus, P. A./ Columbus Endoscopy Center, Inc. I understand that I am financially responsible to Gastroenterology Associates/ Columbus Endoscopy for all charges not covered by assignment and for any expenses that may be incurred for the collection of monies owed. This acknowledgement shall become effective on the signed date and shall continue in effect until another acknowledgement of financial responsibility is signed. I attest to the fact that I have read all of the above and fully understand its meaning.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**AUTHORIZATION FOR PAYMENT OF MEDICARE BENEFITS:** I request that payment of authorized Medicare benefits be made either to me or on my behalf to Gastroenterology Associates of Columbus, P.A./ Columbus Endoscopy Center, Inc. for services furnished to me by any provider of Gastroenterology Associates/ Columbus Endoscopy. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION:** I authorize Gastroenterology Associates of Columbus, P.A./ Columbus Endoscopy Center, Inc. to obtain or release any and all pertinent information they may feel necessary in the treatment of my medical condition, payment processes, or other healthcare operations. I also authorize them to release my protected health information, whether verbal or written, to: \_\_\_\_\_, SS#: \_\_\_\_\_ upon this person's request. **I understand this consent to release records includes but is not limited to any mental, drug, alcohol, hepatitis, or HIV related problems that may be documented in my chart.** This authorization shall become effective on the signed date and shall continue in effect until another authorization to release information is signed and accepted. I attest to the fact that I have read all of the above and fully understand its meaning.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF OUR PATIENT NOTICE OF PRIVACY PRACTICES:** I acknowledge that I have received Gastroenterology Associates of Columbus, P. A./ Columbus Endoscopy Center, Inc.'s Patient Notice of Privacy Practices. I understand that this notice provides me with information regarding my rights to my protected health information.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**EXPLANATION OF PHYSICIAN'S DUTY TO PATIENTS:** This office practice is dedicated specifically to the provision of Gastreenterology Services as they apply to the Internal Medicine Specialty of Gastroenterology. The physicians here are specifically dedicated to the diagnosis and treatment of diseases involving the esophagus, stomach, small and large intestines, liver, pancreas, gallbladder, and biliary system.

Disease processes involving all other organ systems will not be addressed specifically at this clinic and the diagnosis of disease processes outside of the gastrointestinal tract as above described, will not be sought after. Examples of organ systems that will not be addressed here include, but are not limited to breast, lung, heart, and reproductive systems.

If you do not have a primary care provider who evaluates you regularly with regards to any and all disease processes that may affect you, a list of such doctors can be provided on your request. We strongly recommend yearly checkups with such a physician with regards to your general health maintenance. This clinic functions strictly as a specialty and referral clinic in Gastroenterology and does not provide primary care medical services.

I understand the above explanation of physician's duty with respect to this clinic.

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Printed Name of Guardian (if applicable)

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date

I have discussed the above with the patient and they verbalized understanding.

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

**GASTROENTEROLOGY ASSOCIATES OF COLUMBUS, PA**  
**Confidential Health History Form**

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_ **Chart #:** \_\_\_\_\_  
**Primary Doctor:** \_\_\_\_\_ **What is the reason for this visit?** \_\_\_\_\_

**Review of Systems/Symptoms: Check all that apply to your health:**

GASTRO-INTESTINAL	GENERAL	CARDIO-VASCULAR	MUSCLE/JOINT /BONE
<input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Anal pain with passage of stool <input type="checkbox"/> Appetite poor <input type="checkbox"/> Belching/Bloating/Gas <input type="checkbox"/> Black stools <input type="checkbox"/> Bowel changes <input type="checkbox"/> Chest Pain or Discomfort <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Difficulty swallowing / food sticking <input type="checkbox"/> Heartburn <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Rectal pain <input type="checkbox"/> Reflux <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood <input type="checkbox"/> Weight gain <input type="checkbox"/> Weight loss	<input type="checkbox"/> Chills <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Headache  <b>NEUROLOGICAL</b> <input type="checkbox"/> Facial droop <input type="checkbox"/> Numbness / Tingling <input type="checkbox"/> Paralysis  <b>EYE,EAR,NOSE,THROAT</b> <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Earache <input type="checkbox"/> Hoarseness <input type="checkbox"/> Hay fever <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Vision changes	<input type="checkbox"/> Chest pain <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Swelling of lower extremities  <b>PULMONARY</b> <input type="checkbox"/> Cough <input type="checkbox"/> Coughing blood <input type="checkbox"/> Pain with breathing <input type="checkbox"/> Shortness of breath  <b>GENITO-URINARY</b> <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Painful urination  <b>PSYCHIATRIC</b> <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Nervousness	<input type="checkbox"/> Back pain <input type="checkbox"/> Joint pain <input type="checkbox"/> Joint swelling <input type="checkbox"/> Muscle weakness  <b>SKIN</b> <input type="checkbox"/> Bruise easily <input type="checkbox"/> Itching <input type="checkbox"/> Change in moles <input type="checkbox"/> Rash  <b>WOMEN ONLY</b> Date of last period _____ Last pap smear _____ Last mammogram _____ Are you pregnant? _____ Number of children _____

**Past Medical History: Check any that you have or have had in the past:**

<input type="checkbox"/> AIDS <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Anorexia <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Atrial fibrillation <input type="checkbox"/> Barrett's esophagus <input type="checkbox"/> Bleeding disorders <input type="checkbox"/> Bulimia <input type="checkbox"/> Cancer (type) _____ <input type="checkbox"/> Celiac sprue	<input type="checkbox"/> Cirrhosis <input type="checkbox"/> Colon cancer <input type="checkbox"/> Colon polyps <input type="checkbox"/> Congestive heart failure <input type="checkbox"/> COPD <input type="checkbox"/> Crohn's disease <input type="checkbox"/> Deep vein thrombosis (DVT) <input type="checkbox"/> Dementia <input type="checkbox"/> Diabetes <input type="checkbox"/> Diverticulosis <input type="checkbox"/> Diverticulitis <input type="checkbox"/> Elevated liver tests	<input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> GERD <input type="checkbox"/> Glaucoma <input type="checkbox"/> Gout <input type="checkbox"/> Heart attack <input type="checkbox"/> Heart disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Herpes <input type="checkbox"/> High blood pressure <input type="checkbox"/> High cholesterol <input type="checkbox"/> HIV positive <input type="checkbox"/> H. pylori	<input type="checkbox"/> Irritable bowel syndrome <input type="checkbox"/> Jaundice <input type="checkbox"/> Kidney disease <input type="checkbox"/> Kidney stones <input type="checkbox"/> Liver disease <input type="checkbox"/> Lupus <input type="checkbox"/> Melanoma <input type="checkbox"/> Migraine headaches <input type="checkbox"/> Miscarriage x _____ <input type="checkbox"/> NASH / Fatty liver <input type="checkbox"/> Pancreatitis <input type="checkbox"/> Prostate problem	<input type="checkbox"/> Pulmonary embolus <input type="checkbox"/> Psychiatric care <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Sexually transmitted disease <input type="checkbox"/> Sleep apnea <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide attempt <input type="checkbox"/> Thyroid problems <input type="checkbox"/> Transient ischemic attack (TIA) <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Ulcerative colitis <input type="checkbox"/> Ulcers <input type="checkbox"/> Upper GI bleeding <input type="checkbox"/> Other: _____
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**Past Surgical History: Check any that you have had in the past:**

<input type="checkbox"/> Ankle surgery <input type="checkbox"/> Appendectomy <input type="checkbox"/> Back surgery <input type="checkbox"/> Bladder suspension <input type="checkbox"/> Bowel resection <input type="checkbox"/> Breast enlargement <input type="checkbox"/> Breast – Lumpectomy <input type="checkbox"/> Breast – Mastectomy <input type="checkbox"/> Breast reduction <input type="checkbox"/> Cardiac bypass <input type="checkbox"/> Cardiac stents <input type="checkbox"/> Carotid surgery <input type="checkbox"/> Carpal tunnel release <input type="checkbox"/> Cesarean section <input type="checkbox"/> D&C <input type="checkbox"/> Ear surgery	<input type="checkbox"/> Eye surgery <input type="checkbox"/> Foot surgery <input type="checkbox"/> Gallbladder surgery <input type="checkbox"/> Hand surgery <input type="checkbox"/> Hemorrhoidectomy <input type="checkbox"/> Hernia repair – Umbilical <input type="checkbox"/> Hernia repair – Groin <input type="checkbox"/> Hernia repair – Hiatal hernia <input type="checkbox"/> Heart valve replacement – Aortic <input type="checkbox"/> Heart valve replacement – Mitral <input type="checkbox"/> Hip replacement <input type="checkbox"/> Hip surgery <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Kidney surgery <input type="checkbox"/> Kidney removal <input type="checkbox"/> Knee replacement	<input type="checkbox"/> Knee Surgery <input type="checkbox"/> Neck surgery <input type="checkbox"/> Ovarian cyst removal <input type="checkbox"/> Ovary(ies) removal <input type="checkbox"/> Pacemaker / Defibrillator placement <input type="checkbox"/> Prostate surgery <input type="checkbox"/> Shoulder surgery <input type="checkbox"/> Shoulder replacement <input type="checkbox"/> Sinus surgery <input type="checkbox"/> Stomach surgery <input type="checkbox"/> Thyroid surgery <input type="checkbox"/> Tonsillectomy <input type="checkbox"/> Tubal ligation <input type="checkbox"/> Vaginal delivery <input type="checkbox"/> Venous access device (VAD) <input type="checkbox"/> Wisdom tooth extraction	Date of last colonoscopy: _____ Date of last upper scope: _____ Date of last flu shot: _____  <b>Other Surgeries Not Listed:</b> _____ _____ _____ _____
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\*\*\*\*\*Continue on Back\*\*\*\*\*

**Family History: Fill in health information about your family/blood relatives who have had the following:**

**If you are unsure of your family history due to adoption, please check here:**

Disease	Mother	Father	Brother	Sister	Grandmother (M) maternal (P) paternal	Grandfather (M) maternal (P) paternal	Other
Colon polyps					<input type="checkbox"/> M <input type="checkbox"/> P	<input type="checkbox"/> M <input type="checkbox"/> P	
Colon cancer					<input type="checkbox"/> M <input type="checkbox"/> P	<input type="checkbox"/> M <input type="checkbox"/> P	
Cirrhosis					<input type="checkbox"/> M <input type="checkbox"/> P	<input type="checkbox"/> M <input type="checkbox"/> P	
Crohn's disease					<input type="checkbox"/> M <input type="checkbox"/> P	<input type="checkbox"/> M <input type="checkbox"/> P	
Esophageal cancer					<input type="checkbox"/> M <input type="checkbox"/> P	<input type="checkbox"/> M <input type="checkbox"/> P	
Gastric cancer					<input type="checkbox"/> M <input type="checkbox"/> P	<input type="checkbox"/> M <input type="checkbox"/> P	
Hemochromatosis					<input type="checkbox"/> M <input type="checkbox"/> P	<input type="checkbox"/> M <input type="checkbox"/> P	
Liver disease					<input type="checkbox"/> M <input type="checkbox"/> P	<input type="checkbox"/> M <input type="checkbox"/> P	
Pancreatic cancer					<input type="checkbox"/> M <input type="checkbox"/> P	<input type="checkbox"/> M <input type="checkbox"/> P	
Ulcerative colitis					<input type="checkbox"/> M <input type="checkbox"/> P	<input type="checkbox"/> M <input type="checkbox"/> P	
Uterine cancer					<input type="checkbox"/> M <input type="checkbox"/> P	<input type="checkbox"/> M <input type="checkbox"/> P	

**Primary Pharmacy (Include City, State):** \_\_\_\_\_

**Other Pharmacies used:** \_\_\_\_\_

If you brought your medications or medication list with you, please mark the box and you do not have to write out the list. <input type="checkbox"/>		
Medication	Dosage	Times per Day

**ALLERGIES or REACTIONS TO MEDICATIONS:**  
 "NONE" if none known: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you ever had a blood transfusion?    \_\_\_ Yes    \_\_\_ No    If yes When? \_\_\_\_\_  
 Have you ever been vaccinated for Hepatitis A?    \_\_\_ Yes    \_\_\_ No    If yes When? \_\_\_\_\_  
 Have you ever been vaccinated for Hepatitis B?    \_\_\_ Yes    \_\_\_ No    If yes When? \_\_\_\_\_

What is your marital status?    Single \_\_\_    Married \_\_\_    Divorced \_\_\_    Separated \_\_\_    Widowed \_\_\_

<b>HEALTH HABITS: Please mark which substances you use and describe how often you use them.</b>			
	Past Use	Use Now	How Often?
Caffeine			
Cigarettes			
Other tobacco			
Alcohol			
Marijuana			
Other illicit drug use			

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of their staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Full Name Printed: \_\_\_\_\_ Chart #: \_\_\_\_\_