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 appointment reminders and 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 _____

GASTROENTEROLOGY ASSOCIATES OF COLUMBUS, PA
Confidential Health History Form

Name: _____ Date: _____ Age:_____ Birthdate:_____

Primary Doctor:_____What is the reason for this visit?_____
Date of Last Physical Exam:_____ Performed by:_____

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

GENERAL
- ☐ Chills
- ☐ Dizziness
- ☐ Excessive thirst
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Weight loss
- ☐ Sweats

NEUROLOGICAL
- ☐ Facial droop
- ☐ Numbness/Tingling
- ☐ Paralysis

CARDIO-VASCULAR
- ☐ Chest pain
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

GASTRO-INTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Dark stools
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Excessive hunger
- ☐ Gas
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Reflux
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Weight change

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

EYE,EAR,NOSE,THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hoarseness
- ☐ Hay fever
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision- flashes/halos

PULMONARY
- ☐ Asthma
- ☐ COPD
- ☐ Cough
- ☐ Coughing blood
- ☐ Emphysema
- ☐ Pain with breathing
- ☐ Shortness of breath

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Nervousness
- ☐ Suicidal thoughts

MUSCLE/JOINT /BONE
Pain-Weakness-Numbness in:
- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN ONLY
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis

WOMEN ONLY
- ☐ Abnormal pap smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge

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:

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer (type)_____
- ☐ C-Section x _____
- ☐ Chemical dependency
- ☐ Cirrhosis
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gout
- ☐ Heart attack
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Heart stents
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV positive
- ☐ Joint replacement (specify) _____
- ☐ Kidney disease
- ☐ Liver Disease
- ☐ Migraine headaches
- ☐ Miscarriage x _____
- ☐ Multiple sclerosis
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Prostate problem
- ☐ Psychiatric care
- ☐ Stroke
- ☐ Suicide attempt
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Vaginal Delivery x _____
- ☐ Venereal disease
- ☐ Other:_____

Prior Surgeries/Procedures

Approx. date	Type of Surgery and Outcome

*****Continue on Back*****

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

Disease	Mother	Father	Brother	Sister	Grandmother	Grandfather	Other
Heart Disease							
Stroke							
High Blood Pressure							
Diabetes							
Arthritis							
Colon Polyps							
Colon Cancer							
Other Cancer (specify type)							
Liver Disease							
Asthma							
Tuberculosis							

Primary Pharmacy (Include City, State): _____

Other Pharmacies used: _____

Medication	Dosage	Times per Day	Refills Needed (Y/N)

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_____

HEALTH HABITS (X) which substances you use and describe how often you use them.

	Past Use	Use Now	How Often?
Caffeine			
Cigarettes			
Tobacco			
Alcohol			
Other			

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

Signature:_____ Date: _____

Print Full Name: _____

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 Gastrenterology 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