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BOARD CERTIFIED IN INTERNAL MEDICINE AND GASTROENTEROLOGY

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BOARD CERTIFIED IN INTERNAL MEDICINE AND GASTROENTEROLOGY

Patient Registration Form

*Name: _____
Last First Middle Initial

*Social Security # _____ Sex ___ Age ___ Date of Birth _____

*Local Address: _____
Street, Apt. #

*City, State, Zip Code: _____

*Primary Insurance: _____ Secondary Insurance: _____

*Home Phone # _____ Cell Phone # _____

E-mail _____

*If not a Florida Resident, in what state are you a legal Resident? _____

*If you only live in Florida in the winter, what months of the year are you here? _____

*Out of State Address & Phone # (if applicable) _____

*Spouse' Information (if applicable): Spouse's Name: _____

***Patient Employer Information:**

Employer: _____ Phone #: _____

Employer Address: _____ Occupation: _____

34041 US 19 N., Suite A
Palm Harbor, FL 34684
(727) 786-0017

646 Virginia Street, 5TH floor
Dunedin, FL 34698
(727) 734-6415

Name: _____ Age: _____

How did you hear about us: _____ ?

Do you have a primary care physician: No/ Yes,

Dr. _____ Phone Number: _____

Reason for today's visit: _____

Allergies: Penicillin/Sulfa/Codeine/Other:

List all medications you are currently taking: (use back if needed)

On the following pages, please circle the appropriate words, Y or N, or fill in the blanks as indicated. This questionnaire has five (5) pages; please notify us if you are missing any pages. Thank you.

Have you ever had any of the following? (Circle all that apply)

Ulcers, hiatal hernia, Barrett's esophagus, esophageal stricture/ring, esophageal varices, Helicobacter pylori, Colon polyps, colon cancer, irritable bowel syndrome, Crohn's disease, ulcerative colitis, diverticulosis, hemorrhoids, fistula, anal fissure.

Hepatitis, cirrhosis, gallstones, pancreatitis.

Hypercholesterolemia, hypertension, angina, heart attack,

heart murmur, endocarditis, atrial fibrillation,
irregular heart rhythm.

COPD/emphysema, asthma, TB exposure.

Diabetes, hypothyroidism, osteoporosis, osteopenia.

Stroke, TIA, migraines.

Arthritis, chronic back pain, fibromyalgia.

Depression, anxiety, bipolar disorder.

Other cancers: skin, breast, uterine, ovarian, prostate

Have you had any of the following surgery?

Appendectomy, colectomy (partial, right, left, or sigmoid), small
bowel resection, hemorrhoidectomy, colostomy, ileostomy,
hiatal hernia surgery, gastric bypass/stapling weight loss
surgery, ulcer surgery, gallbladder, umbilical hernia repair,
inguinal hernia repair (right, left, both), tonsillectomy,
hysterectomy, tubal ligation, coronary artery bypass,
C-Section(s) (#? ___), mastectomy, prostate surgery,
knee surgery, hip surgery, shoulder surgery, carpal tunnel
release, implanted defibrillator (Medtronic, Guidant, Other),
pacemaker, heart valve replacement (Aortic, mitral, not known).

Have you ever had an upper endoscopy? Y N Date: _____
Have you ever had your esophagus dilated? Y N Date: _____
Have you ever had a colonoscopy? Y N Date: _____

Has a family member (not yourself or spouse) had the following (circle)?

Colon and/or rectal cancer? Who/age? _____
Esophagus cancer? Who/age? _____
Stomach cancer? Who/age? _____
Liver cancer? Who/age? _____
Pancreatic cancer? Who/age? _____
Colon polyps? Who/age? _____

Cancer of: breast, uterus, ovaries.

Liver disease? Who? _____ Alcohol related? Y N
Ulcerative Colitis? Who? _____
Crohn's disease? Who? _____

Personal History

Do you smoke? Y N How long? _____ Packs per day? ____
Pipe? Cigars? Chew tobacco?
Ex-smoker? When did you quit? _____
Have you ever used heroin/cocaine/marijuana/
methamphetamine? Y N Intravenously? Y N
Have you had a blood transfusion? Y N Year? _____
Do you have tattoos or body piercings? Y N
Alcohol use: Never, social, rarely, daily, heavily.
Beer? Liquor? Wine? _____ times per week/day/month. Ever
drink heavily? Y N

Married/Divorced/Separated/Widowed/Significant Other
How many children? _____

Occupation: _____? Retired? Y N

Do you **currently** have any of the following? (Please circle):

General: Fever, weight loss, fatigue, general weakness, loss of appetite.

Skin: Rash, itching.

Eyes: Abrupt change in vision, blurred vision, double vision

ENT: Hearing loss, frequent sore throats, bleeding gums.

Heart: Palpitations, fainting spells, dizziness, ankle swelling, chest pain, angina, irregular heart beat.

Respiratory: Cough, shortness of breath, coughing up blood, wheezing.

Neurological: Seizures, stroke, recent loss of consciousness, arm weakness (R, L, both), leg weakness (R, L, both), arm numbness (R, L, both), leg numbness (R, L, both).

Psychiatric: Depression, anxiety, panic attacks, other? _____

Genitourinary: Frequent urination, blood in urine, pain with urinating, impotence.

Endocrine: Unusual weight loss or gain, excessive thirst, excessive urination, hair loss or gain.

Hematologic: Spontaneous bruising, anemia.

Allergic: Food sensitivities (shellfish/milk products/nuts/gluten/other), animal sensitivities (cats/dogs/other), insect sensitivities (bees, wasps, spiders, fire ants, other).

Musculoskeletal: Arthritis, back pain, muscle cramps.

Females only:

Excessive bleeding with period? Y N

Menopause occurred at age _____

Number of pregnancies: _____

Number of children: _____

Breast lumps? Y N

Current Gastrointestinal/Liver Problems:

(Please circle any problem you are having at the *present* time)

- Excessive Salivation
- Acid Regurgitation/Sour taste
- Heartburn
- Food sticks when swallowing
- Belching
- Nausea
- Vomiting
- Vomiting blood
- Pain above the belly button
- Pain below the belly button
- Gas from below
- Change in bowel habits
- Constipation
- Diarrhea
- Black stool
- Bloody stool
- Blood with wiping only
- Anal or rectal pain
- Leakage of stool/soiling
- Jaundice/Yellow skin or eyes
- Hepatitis

Please add any other remarks you feel will help us better understand why you are here today:

Required Signatures

For Medicare/Medicare HMO Patients:

I request that payment of authorized Medicare/HMO benefits be made either to me or on my behalf to Advanced Gastroenterology Associates for any services furnished. I authorize any holder of medical information about me be released to the Insurance Health Care Finance Administration and it's agents to determine benefits payable for related services. I also request that payment for authorized Medigap/Secondary insurance carrier benefits be made on my behalf to Advanced Gastroenterology Associates. I authorize any holder of medical information about me be released to the Medigap/Secondary insurance carrier and it's agents to determine benefits payable for related services. I understand that I do not need to provide my Medigap/Secondary insurance carrier with information concerning Medicare claims because my signing this authorization will allow Medicare payment information to cross-over automatically.

Patient's Signature/Representative

Date

For Medicaid/PPO/HMO/Commercial Insurance Patients:

I authorize release of any medical information about me to be released to my insurance carrier and it's agents to determine benefits payable for related services. I also request that payment for authorized benefits be made on my behalf to Advanced Gastroenterology Associates.

Patient's Signature/Representative

Date

All Patients

I understand that as a courtesy Advanced Gastroenterology Associates will bill my insurance carrier for services rendered. I understand that I am financially responsible and agree to all charges for myself and for the members of my family, as applicable, promptly upon presentation thereof. Charges as shown by statements are agreed to be correct unless protested in writing within thirty days of date of service. It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon. In the event that legal action should become necessary to collect an unpaid balance due, I agree to pay reasonable attorney's fees and other such costs as determined by the Pinellas County court.

Patient's Signature/Representative

Date

Notice of Privacy Practices

Acknowledgement:

I have read the copy of the Advanced Gastroenterology Associates Notice of Privacy Practices.

Date: _____

Print Name: _____

Signature: _____

If signing as a parent or guardian, please note the name of the patient:

Print Name: _____

I understand my medical information and reports will be automatically sent to my primary care physician. I authorize additional release of my medical information and records to the following:

Name: _____ Relationship _____

Name: _____ Relationship _____

Name: _____ Relationship _____

Name: _____ Relationship _____

Patient's Signature: _____ Date: _____