PRIME HealthCare, PC

GASTROENTEROLOGY

_____

_____

_____

Patient Intake Form

Name: _____ Age: _____ Date of Birth: _____ Date: _____

Height: _____ Weight: _____ Who is your primary doctor? _____ Referring Physician? _____

Reason for seeing a Gastroenterologist: _____

Have you been seen by a doctor in our group ☐ Yes _____ ☐ No
Name of Physician

Were you referred to a specific doctor in our group? Yes No
If yes, (circle) Dr. Van Linda Dr. Zaldonis Dr. Petruff Dr. Gazi Dr. Jamil Dr. Ayyagari

Have you had a __ Colonoscopy or __ Sigmoidoscopy done in the past 10 years? Yes No
If yes, what year was it performed? _____ Were Polyps/Colon Cancer found? Yes No

Who did procedure _____

CURRENT SYMPTOMS: (check all that apply) ☐ None

___ Abdominal pain
___ Nausea
___ Vomiting
___ Bloody vomiting
___ Fevers
___ Chills
___ Loss of appetite
___ Weight loss
___ Change in bowel habits
___ Diarrhea
___ Constipation
___ Rectal bleeding
___ Blood in stool
___ Blood on toilet paper
___ Hemorrhoids
___ Anal pain
___ Black, tarry stool
___ Gas/bloating
___ Heartburn
___ Acid reflux
___ Belching/Burping
___ Indigestion
___ Lactose intolerance
___ Difficulty swallowing
___ Food sticking in esophagus
___ Painful swallowing
___ Jaundice
___ Abnormal liver tests
___ Anemia
___ Stool incontinence

PAST MEDICAL/SURGICAL HISTORY: (check all that apply)

___ None
___ High Blood Pressure
___ Heart Attack/MI
___ Heart Disease/Stents
___ Elevated Cholesterol
___ Heart Valve Problem/Murmur
___ Congestive Heart Failure
___ Atrial Fibrillation
___ Heart Arrhythmia
___ Blood Transfusions
___ Pacemaker/Defibrillator
___ Asthma
___ Lupus
___ Cancer, type(s): _____
___ Emphysema/COPD
___ Lynch Syndrome
___ Tuberculosis
___ Sleep Apnea
___ Lung Clots
___ Diabetes Mellitus
___ Seizure Disorder
___ Stroke/TIA
___ Alzheimer's Disease
___ Parkinson's Disease
___ Thyroid Disease
___ Bleeding Disorder
___ Kidney problems
___ Hemophilia
___ GERD/Acid Reflux
___ Barrett's Esophagus
___ Hiatal Hernia
___ Stomach / Duodenal Ulcer
___ Celiac Disease
___ Helicobacter Pylori
___ Irritable Bowel (IBS)
___ Crohn's Disease
___ Ulcerative Colitis
___ Pancreatitis
___ Hepatitis
___ Hemodialysis
___ Other: _____
___ Fatty liver
___ Diverticulosis
___ Diverticulitis
___ Anemia
___ Depression
___ Anxiety Disorder
___ Bipolar Disorder
___ Schizophrenia
___ Arthritis
___ Osteoporosis
___ Fibromyalgia
___ HIV/AIDS
___ Liver Cirrhosis

PAST SURGICAL HISTORY: (check all that apply)

___ None
___ Coronary bypass
___ Heart valve replacement
___ Pacemaker placement
___ Defibrillator (AICD) placement
___ Removal of gallbladder
___ Removal of appendix
___ Hiatal hernia repair
___ Removal of uterus
___ Removal of ovary/ovaries
___ Tubaligation
___ C-section
___ Prostate surgery
___ Thyroid surgery
___ Lung surgery
___ Gastric bypass surgery
___ Colon surgery
___ Stomach ulcer surgery
___ Inguinal hernia repair
___ Abdominal hernia repair
___ Total knee replacement
___ Total hip replacement
___ Bladder suspension
___ Rectal prolapse surgery
___ Other _____
_____

*** 2 sided form - Please be sure to complete both sides**

Turn Over

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Allergies to Medicine:

Are you allergic to any medication? Yes No Are you allergic to latex? Yes No
If yes, please name medications & reactions: _____
_____

Have you ever had problems with Anesthesia? Yes No

Medications:

Do you take aspirin or arthritis medication (Ibuprofen, Naproxen, Aleve, Motrin, Advil)? Yes No
If yes, please name medication & frequency: _____

Do you take blood thinners (Coumadin, Warfarin, Heparin, Lovenox, Plavix)? Yes No
If yes, please name medication & frequency: _____

Please list other medications you are taking (include "over-the-counter' medicine and doses) ☐ None

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

Social History/Martial Status:
___Single ___Married ___ Divorced ___Separated ___Widowed

Circle the number of years of formal education you have completed.
8 9 10 11 12 13 14 15 16 >16

Your occupation: _____ Retired_____ Unemployed_____ Disabled ____

Do you/have you ever used tobacco? ____Yes ___No Packs per day?_____ Years?_____ Date Quit? _____

Do you use chewing tobacco? ____Yes ___No Frequency? _____ Years?_____ Date Quit? _____

Do you drink alcohol? ____Yes ___No ___Beer ___Wine ___Liquor How often?_____ How much?_____

Have you ever used street/illicit drugs? ____Yes ____No Type_____ Last use _____

FAMILY HISTORY
Does anyone in **YOUR FAMILY** have the following illnesses? Check all that apply and write in the relationship of family member, ie. Mother, maternal aunt, paternal uncle, sister.

_____Colon polyps	_____Breast Cancer	_____Skin cancer (ie. Melanoma)	_____Hepatitis
_____Colon cancer	_____Prostate Cancer	_____Liver cancer	_____Bleeding problems
_____Rectal cancer	_____Stomach cancer	_____Pancreatic cancer	_____Ulcerative Colitis
_____Uterine/ Cervical cancer	_____Small bowel cancer	_____Kidney/Ureter cancer	_____Celiac Disease
_____Ovarian Cancer	_____Esophageal cancer	_____Crohn's Disease	_____Gallbladder Disease

Other Cancer (please describe) _____
_____

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

Signature: _____ **Date:** _____

*** 2 sided form - Please be sure to complete both sides**

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HIPAA PATIENT CALLING INFORMATION

Name:_____ Date of Birth:_____

With whom do you allow us to share your personal medical information?

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

How may we contact you?

Please list in the order the way you wish to be contacted. (1-3)

____ **Home Phone**:_____

_____ DO NOT leave a message
_____ Leave brief message, return#
_____ May leave a detailed message

____ **Work Phone**:_____

_____ DO NOT leave a message
_____ Leave brief message, return #
_____ May leave a detailed message

____ **Cell Phone:**_____

_____ DO NOT leave a message
_____ Leave brief message, return#
_____ May leave a detailed message

If you would like to communicate with our office via email, we encourage you to sign up for MyCare. This is a secure web portal. You can do this by going to www.stfranciscare.org/mycare . There is also an app on Googleplay or the App Store called My Chart.

**I understand that it is my responsibility to notify the office of any changes in my calling or HIPAA communication information.

PATIENT SIGNATURE_____ **DATE**_____

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Acknowledgement of Receipt of Privacy Practices

Name of Patient: _____ Date of Birth: _____

I hereby acknowledge that I was offered and/or reviewed a copy of Prime Healthcare's Notice of Privacy Practices. I understand that a copy of the current Notice of Privacy Practice's will be posted in the reception area, and is available online at www.primehc.com/patient-forms. I know that I may request a copy at any time.

I acknowledge that Prime Healthcare utilizes an electronic medical record that is affiliated with Saint Francis Hospital/Trinity of New England and its affiliates. Use and/or disclosure of my protected health information by Prime Healthcare PC or its affiliates will be for the purposes of carrying out treatment, obtaining payment or conducting certain healthcare operations. Protected health information will be used or disclosed in accordance with Connecticut and Federal law, which may require me to provide specific authorization. Complete details are listed in our Notice of Privacy Practices.

This policy if applicable to all offices within Prime Healthcare. I understand that I may contact the Privacy Officer at 860-263-0253 if I have any questions or concerns.

Signature:

_____ Date:

If not signed by the patient, please indicate your releationsthip to the patient: _____

For Office Use Only:

__ Received
__ Acknowledged Refused

I made a good faith effort to obtain a written acknowledgement of the receipt of Notice of Privacy Practices from the above-named patient, but was unable to because:
Efforts to Obtain:

___ Individual refused
___ Emergency treatment situation
___ Individual not able to sign due to medical reasons
___ Other: _____

Name and Title of Employee

_____ Date:

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Patient Demographic Form

www.primehc.com

Patient Last Name	Patient First Name	MI	Date of Birth	SEX ☐Female ☐Male ☐Other: _____
Social Security #	Email Address			Marital Status ☐S ☐M ☐D ☐W

Employment Status: ☐Employed ☐Retired ☐Self-Employed ☐Part-Time Student ☐Full-Time Student ☐Disabled ☐Unemployed

The Federal Government asks providers to ask the questions below.

Race	Ethnicity	Language
☐Caucasian ☐Black ☐Asian ☐Native Indian / Native Alaskan ☐Native Hawaiian / Pacific Islander ☐Other Race ☐Unknown	☐Hispanic/Latino ☐Not Hispanic/Latino ☐Caucasian ☐Other ☐Unknown	☐English ☐Spanish ☐French ☐Polish ☐Vietnamese ☐Sign ☐Other

Home Address	City	State	Zip Code
Billing / Mailing Address	City	State	Zip Code

Preferred Phone: ☐Home ☐Cell ☐Work Leave detailed message?: ☐Yes ☐No	Additional Phone: ☐Home ☐Cell ☐Work Leave detailed message?: ☐Yes ☐No	Additional Phone: ☐Home ☐Cell ☐Work Leave detailed message?: ☐Yes ☐No

Employer	Employer Address	City	State	Zip Code

Primary Care Provider:	**Referring Physician:**	**Ophthalmologist:**
Primary Insurance Coverage Name	Insurance ID #: _____ Group #: _____	Effective Date: _____
Subscriber: ☐Patient ☐Spouse ☐Parent ☐Other Subscriber Name:	Date of Birth: _____ Social Security #: _____	Employer:
Secondary Insurance Coverage Name	Insurance ID #: _____ Group #: _____	Effective Date: _____ Copay $: _____ Deductible: _____
Subscriber: ☐Patient ☐Spouse ☐Parent ☐Other Subscriber Name:	Date of Birth: _____ Social Security #: _____	Employer:

Emergency Contact	Relationship to Patient: ☐Wife ☐Husband ☐Child ☐Parent ☐Friend ☐Guardian ☐Other
	Name: Contact Phone: W ork Phone:

I hereby authorize direct payment to medical/surgical benefitsto Prime Healthcare, PC for services rendered by our providers. I understand that I am financially responsible for any balance not covered by my insurance. I certify that the information given by me above is correct. I hereby authorize Prime Healthcare, PC, its agents and representatives,to access information regarding my person, whereabouts, and to release all necessary information to my insurance company regarding my medical history, examinations, and treatments for the purposes of processing ny insurance claims. A photocopy of my signature is valid as the original.

Signature: _____ Date: _____

PARENT / GUARDIAN INFORMATION

Relationship to Patient: ☐Parent ☐Guardian ☐Brother/Sister ☐Power of Attorney ☐Other

Name:	Social Security #:	Date of Birth:	Contact #:

PHARMACY NAME/ADDRESS: **Phone Number:**