GASTROENTEROLOGY

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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. Josephson Dr. Van Linda Dr. Zaldonis Dr. Petruff Dr. Gazi Dr. Munsaf

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

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**

PATIENT INFORMATION FORM

www.primehc.com

Patient Name

SEX ☐ Female ☐ Male

Answers to Questions Below ARE Required by the Federal Government American Recovery & Reinvestment Act of 2009

Social Security # | Date of Birth | Marital Status ☐ S ☐ M ☐ D ☐ W

Email Address

Race
☐ Caucasian
☐ Black
☐ Asian
☐ American Indian/Native Alaskan
☐ Native Hawaiian/Pacific Islander
☐ Other Race
☐ Unknown

Ethnicity
☐ Hispanic/Latino
☐ Not Hispanic/Latino
☐ Caucasian
☐ Other
☐ Unknown

Language
☐ English
☐ Spanish
☐ French
☐ Polish
☐ Vietnamese
☐ Sign
☐ Other

Employment Status

☐ Employed ☐ Retired ☐ Part-Time Student ☐ Full-Time Student
☐ Self-Employed ☐ Disabled ☐ Unemployed

Mailing Address | City | State | Zip Code

Home # | Mobile # | Work # & Extension

Employer | Employer Address | City | State | Zip Code

Referring Physician | Primary Care Physician

Primary Insurance Plan Name | ID #

Effective Date | Group # | Visit Copay $ Amount | Deductible $ Amount

Subscriber: ☐ Patient ☐ Parent ☐ Spouse ☐ Other ____________

Subscriber Name ____________ DOB: ____________

Social Security # | Employer

Secondary/Supplemental Insurance Plan Name | ID #

Effective Date | Group # | Visit Copay $ Amount | Deductible $ Amount

Subscriber: ☐ Patient ☐ Parent ☐ Spouse ☐ Other ____________

Subscriber Name ____________ DOB: ____________

Social Security # | Employer

Referral Source

☐ Specialist ☐ PCP
☐ Physical Therapist ☐ Walk-In
☐ SFH-ER ☐ HH-ER
☐ Patient ☐ Friend
☐ Radio Ad ☐ TV Ad
☐ Yellow Pages ☐ Internet
☐ Educational Series ☐ Website
☐ Newspaper/Magazine Ad
☐ Marketing Campaign
☐ Other ____________

Emergency Contact

Relationship to Patient: ☐ Wife ☐ Husband ☐ Child ☐ Parent ☐ Friend ☐ Guardian ☐ Other ____________

Name (F/M/L) | Contact Phone # | Work Phone #

I hereby authorize direct payment of medical/surgical benefits to 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 in applying for payment is correct. I hereby authorize PRIME Healthcare, PC, its agents and representatives, to access information regarding my person, whereabouts and medical history and to release all necessary information to my insurance company regarding my medical history, examinations, and treatment for the purposes of processing my insurance coverage. A photocopy of my signature is as valid as the original.

Signature ____________ **Date** ____________

PARENT / GUARDIAN INFORMATION

Patient's Relationship: ☐ Child ☐ Wife ☐ Husband ☐ Parent ☐ Brother/Sister ☐ Grandparent ☐ Aunt/Uncle ☐ Niece/Nephew ☐ Power of Attorney ☐ Other ____________

Name (F/M/L) | Social Security # | DOB

Pharmacy Name/Address | **Phone#**

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. (1-4)

____ **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

____ **Email Address:** ______________________________

(only use email to mail forms until our portal email is available)

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

Patient Signature ______________________________ Date ____________

P R I M E   H E A L T H C A R E ,   P . C .

Gastroenterology

Ronald P. Josephson, M.D.
Brian Van Linda, M.D., MBA
Anthony Zaldonis, M.D.
Carol A. Petruff, M.D.
Golam R. Gazi, M.D., F.R.C.P.,(C)
Swapnil D. Munsaf, M.D.

Janice M. Whedon, APRN

PATIENT INFORMED CONSENT FORM

1. **PROCEDURE AND ALTERNATIVE:** I, ______________________________,(patient/guardian) give consent for the doctors of Prime Health Care, PC: GI Group to perform a **screening colonoscopy.**

2. I understand the reason for the procedure is for colon cancer screening/prevention.

3. **RISKS/DANGERS**: I understand that this procedure may have risks and dangers that can include, but are not limited to: perforation (puncture of the colon wall), missed lesions, bleeding, infection, cardiac complications including heart attack, abnormal heart rhythms, and respiratory issues.

4. **ANESTHESIA:** A doctor or specially trained nurse will give me medicine to keep me from feeling the pain of the procedure. This is called conscious sedation/anesthesia. The medicine could make me relax or sleep. This medicine could cause problems. The doctor or specially trained nurse will decide what medicine to give me.

5. **ADDITIONAL PROCEDURES**: If my physician discovers a different unsuspected condition at the time of my procedure, I authorize her/him to perform such other procedures as deemed necessary.

6. **RESULTS NOT GUARANTEED**: I understand that a screening colonoscopy is the best test to prevent colon cancer but does not completely eliminate the risk of subsequently developing colon cancer.

7. **FINANCIAL RESPONSIBILITY**: I understand I am responsible for any deductibles, co-payments, co-insurance or amounts not covered by the insurance carrier for my procedure(s). **In addition, I am aware that if I cannot attend my scheduled procedure(s), I must call at least 48 hours in advance to avoid a $150 no show /cancellation fee.**

8. **PATIENT'S CONSENT**: I have read and fully understand all materials offered to me in regards to this procedure. I have read and fully understand this consent form. My questions have been answered. I have no more questions.

______________________________   ______________   ______________
Patient signature   Date   Patient Date of Birth

☐ **If you wish to be seen in the office prior to your colonoscopy, please check here. Please include this form with all the other forms in the packet and mail back to us.**

Acknowledgement of Receipt of Notice of Privacy Practices

Name of Patient: ______________________________ Date of Birth: ___________________

I hereby acknowledge that I reviewed a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that it may be amended at any time, and I may request a copy of the Notice of Privacy Practices at any time.

This policy is applicable to all offices within Prime Healthcare. I understand that if I have questions or complaints, I may contact the Privacy Officer at (860) 263-0253 EXT 231.

Signature: ________________________________ Date: ____________________________

If not signed by the patient, please indicate your relationship to the patient: _________________

***For Office Use Only*:**

- ❑ Signed form received by: ________________________________
- ❑ Acknowledgment refused:

  Efforts to obtain: ____________________ Reasons for refusal: ____________________

BEFORE WE CAN SCHEDULE YOUR PROCEDURE WE WILL NEED A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD.

PLEASE ENCLOSE WITH YOUR PAPERWORK.

THANK YOU

PRIME HEALTHCARE