



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. Zaldonis Dr. Petruff Dr. Jamil Dr. Ayyagari Dr. Corredine

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

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

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

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

PAST SURGICAL HISTORY: (check all that apply)

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



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: _____

Patient Last Name		Patient First Name		MI	Date of Birth	SEX <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other: _____	
Social Security #		Email Address			Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W		
Employment Status: <input type="checkbox"/> Employed <input type="checkbox"/> Retired <input type="checkbox"/> Self-Employed <input type="checkbox"/> Part-Time Student <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Disabled <input type="checkbox"/> Unemployed							
The Federal Government asks providers to ask the questions below.							
Race <input type="checkbox"/> Caucasian <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Native Indian / Native Alaskan <input type="checkbox"/> Native Hawaiian / Pacific Islander <input type="checkbox"/> Other Race <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Caucasian <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> French <input type="checkbox"/> Polish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Sign <input type="checkbox"/> Other	
Home Address				City	State	Zip Code	
Billing / Mailing Address				City	State	Zip Code	
Preferred Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work		Additional Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work		Additional Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work			
Leave detailed message?: <input type="checkbox"/> Yes <input type="checkbox"/> No		Leave detailed message?: <input type="checkbox"/> Yes <input type="checkbox"/> No		Leave detailed message?: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Employer	Employer Address			City	State	Zip Code	
Primary Care Provider:			Referring Physician:			Ophthalmologist:	
Primary Insurance Coverage Name			Insurance ID #: _____ Group #: _____		Effective Date: _____		
Subscriber: <input type="checkbox"/> Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other Subscriber Name:			Date of Birth: _____ Social Security #: _____		Employer:		
Secondary Insurance Coverage Name			Insurance ID #: _____ Group #: _____		Effective Date: _____ Copay \$: _____ Deductible: _____		
Subscriber: <input type="checkbox"/> Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other Subscriber Name:			Date of Birth: _____ Social Security #: _____		Employer:		
Emergency Contact	Relationship to Patient: <input type="checkbox"/> Wife <input type="checkbox"/> Husband <input type="checkbox"/> Child <input type="checkbox"/> Parent <input type="checkbox"/> Friend <input type="checkbox"/> Guardian <input type="checkbox"/> Other						
	Name:		Contact Phone:			Work Phone:	
I hereby authorize direct payment to 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 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 my insurance claims. A photocopy of my signature is valid as the original.							
Signature: _____				Date: _____			
PARENT / GUARDIAN INFORMATION							
Relationship to Patient: <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Brother/Sister <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Other							
Name:		Social Security #:		Date of Birth:		Contact #:	
PHARMACY NAME/ADDRESS:						Phone Number:	



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** _____



Cancellation, No Show, Reschedule Policy

Thank you for choosing Prime Healthcare, PC for your medical needs. We are committed to providing the highest level of care to each of our patients.

Our practice has a cancellation policy to encourage patients to keep their appointments or to give us notice if they need to reschedule.

Patients must call to cancel or reschedule an appointment at least 24 hours in advance of regular office appointments and 48 hours in advance of a procedure or sleep study.

Patients who fail to cancel an appointment within an appropriate timeframe may receive a missed appointment fee, based on the appointment types below:

Service	Charge Amount
New Patients	\$50
Office visit	\$25
Physical	\$50
Procedure	\$150
Sleep Studies	\$250

We define a missed appointment as:

- No call/no show, or
- Canceling or rescheduling with less than 24 - 48 hours' notice

If a patient misses (3) appointments in a 12-month period, we may discharge that patient from the practice.

Please let us know if you have any questions regarding this policy, or if you may have difficulty keeping your appointments.

Thank you. We look forward to providing your care.

Please sign below to acknowledge receipt of our policy.
Parent or Legal Authorized Representative

Signature

Print Name

Date of Birth



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 relationship 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: