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 our 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 #: _____

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 _____

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 Gastroenterology 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

GASTROENTEROLOGY ASSOCIATES OF COLUMBUS, PA
Confidential Health History Form

Name: _____ Date: _____ Birthdate: _____ Chart #: _____
Primary Doctor: _____ What is the reason for this visit? _____

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

GASTRO-INTESTINAL
- ☐ Abdominal Pain
- ☐ Anal pain with passage of stool
- ☐ Appetite poor
- ☐ Belching ☐ Bloating ☐ Gas
- ☐ Black stools
- ☐ Bowel changes
- ☐ Chest Pain or Discomfort
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty swallowing / food sticking
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Rectal pain
- ☐ Reflux
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Weight gain
- ☐ Weight loss

GENERAL
- ☐ Chills
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Headache

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

EYE,EAR,NOSE,THROAT
- ☐ Bleeding gums
- ☐ Earache
- ☐ Hoarseness
- ☐ Hay fever
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision changes

CARDIO-VASCULAR
- ☐ Chest pain
- ☐ Irregular heart beat
- ☐ Rapid heart beat
- ☐ Swelling of lower extremities

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

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

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Nervousness

MUSCLE/JOINT /BONE
- ☐ Back pain
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle weakness

SKIN
- ☐ Bruise easily
- ☐ Itching
- ☐ Change in moles
- ☐ Rash

WOMEN ONLY

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
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Barrett's esophagus
- ☐ Bleeding disorders
- ☐ Bulimia
- ☐ Cancer (type) _____ _____
- ☐ Celiac sprue
- ☐ Cirrhosis
- ☐ Colon cancer
- ☐ Colon polyps
- ☐ Congestive heart failure
- ☐ COPD
- ☐ Crohn's disease
- ☐ Deep vein thrombosis (DVT)
- ☐ Dementia
- ☐ Diabetes ☐ Type 1 ☐ Type 2
- ☐ Diverticulosis
- ☐ Diverticulitis
- ☐ Elevated liver tests
- ☐ Emphysema
- ☐ Epilepsy
- ☐ GERD
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart attack
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV positive
- ☐ H. pylori
- ☐ Irritable bowel syndrome
- ☐ Jaundice
- ☐ Kidney disease ☐ Dialysis
- ☐ Kidney stones
- ☐ Liver disease
- ☐ Lupus
- ☐ Melanoma
- ☐ Migraine headaches
- ☐ Miscarriage x _____
- ☐ NASH / Fatty liver
- ☐ Pancreatitis
- ☐ Prostate problem
- ☐ Pulmonary embolus
- ☐ Psychiatric care
- ☐ Rheumatoid arthritis
- ☐ Sexually transmitted disease
- ☐ Sleep apnea
- ☐ Stroke
- ☐ Suicide attempt
- ☐ Thyroid problems
- ☐ Transient ischemic attack (TIA)
- ☐ Tuberculosis
- ☐ Ulcerative colitis
- ☐ Ulcers
- ☐ Upper GI bleeding
- ☐ Other:_____

Past Surgical History: Check any that you have had in the past:

- ☐ Ankle surgery
- ☐ Appendectomy
- ☐ Back surgery
- ☐ Bladder suspension
- ☐ Bowel resection
- ☐ Breast enlargement
- ☐ Breast – Lumpectomy
- ☐ Breast – Mastectomy
- ☐ Breast reduction
- ☐ Cardiac bypass
- ☐ Cardiac stents
- ☐ Carotid surgery
- ☐ Carpal tunnel release
- ☐ Cesarean section
- ☐ D&C
- ☐ Ear surgery
- ☐ Eye surgery
- ☐ Foot surgery
- ☐ Gallbladder surgery
- ☐ Hand surgery
- ☐ Hemorrhoidectomy
- ☐ Hernia repair – Umbilical
- ☐ Hernia repair – Groin
- ☐ Hernia repair – Hiatal hernia
- ☐ Heart valve replacement – Aortic
- ☐ Heart valve replacement – Mitral
- ☐ Hip replacement
- ☐ Hip surgery
- ☐ Hysterectomy
- ☐ Kidney surgery
- ☐ Kidney removal
- ☐ Knee replacement
- ☐ Knee Surgery
- ☐ Neck surgery
- ☐ Ovarian cyst removal
- ☐ Ovary(ies) removal
- ☐ Pacemaker / Defibrillator placement
- ☐ Prostate surgery
- ☐ Shoulder surgery
- ☐ Shoulder replacement
- ☐ Sinus surgery
- ☐ Stomach surgery
- ☐ Thyroid surgery
- ☐ Tonsillectomy
- ☐ Tubal ligation
- ☐ Vaginal delivery
- ☐ Venous access device (VAD)
- ☐ Wisdom tooth extraction

Date of last colonoscopy: _____

Date of last upper scope: _____

Date of last flu shot: _____

Other Surgeries Not Listed:

_____

_____

_____

_____

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

Family History: Fill in health information about your family/blood relatives who have had the following:							
If you are unsure of your family history due to adoption, please check here: □							
Disease	**Mother**	**Father**	**Brother**	**Sister**	**Grandmother** (M) maternal (P) paternal	**Grandfather** (M) maternal (P) paternal	**Other**
Colon polyps					□ M □ P	□ M □ P	
Colon cancer					□ M □ P	□ M □ P	
Cirrhosis					□ M □ P	□ M □ P	
Crohn's disease					□ M □ P	□ M □ P	
Esophageal cancer					□ M □ P	□ M □ P	
Gastric cancer					□ M □ P	□ M □ P	
Hemochromatosis					□ M □ P	□ M □ P	
Liver disease					□ M □ P	□ M □ P	
Pancreatic cancer					□ M □ P	□ M □ P	
Ulcerative colitis					□ M □ P	□ M □ P	
Uterine cancer					□ M □ P	□ M □ P	

Primary Pharmacy (Include City, State): _____

Other Pharmacies used: _____

If you brought your medications or medication list with you, please mark the box and you do not have to write out the list. □		
Medication	**Dosage**	**Times per Day**

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: Please mark which substances you use and describe how often you use them.			
	Past Use	**Use Now**	**How Often?**
Caffeine			
Cigarettes			
Other tobacco			
Alcohol			
Marijuana			
Other illicit drug use			

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

Signature: _____ Date: _____

Print Name: _____ Chart #: _____