

**PATIENTS PERSONAL HISTORY**

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

(Last Name First Middle)

Place of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

**Please circle one:**

**Sex:** (M) / (F) **Marital Status:** Single / Married / Divorced **Preferred Language:** English / Indian / Spanish / Russian / Other

**Ethnicity:** Hispanic or Latino / Not Hispanic or Latino / Decline to Report

**Race:** White / African American / Hispanic / Asian / American Indian / Native Hawaiian or Pacific Islander / other / Decline to Report

Email Address if available: \_\_\_\_\_ Religion: \_\_\_\_\_

Address: \_\_\_\_\_

(Address City State Zip)

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

Employer Name & Phone #: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone#: \_\_\_\_\_

Emergency Contact Address: \_\_\_\_\_

Family or Referring Physician: \_\_\_\_\_

**FAMILY HISTORY**

(If living please give age and health-----If deceased please give age at death and cause)

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

How many Brothers: \_\_\_\_\_ Sisters: \_\_\_\_\_ How many Sons: \_\_\_\_\_ Daughters: \_\_\_\_\_

**Do you know of any blood relative who has or had: (Circle and give relationship)**

Colon Cancer ( YES / NO ) Any other Cancer ( YES / NO ) Colitis ( YES / NO ) Crohn's Disease ( YES / NO )

Any other illness in the Family? \_\_\_\_\_

**PERSONAL HABITS: (Circle)**

Do you smoke? ( YES / NO ) Cigarettes \_\_\_\_\_ Pipe \_\_\_\_\_ Cigars \_\_\_\_\_ How many years? \_\_\_\_\_

Do you regularly drink alcohol / Beer? ( YES / NO ) Amount & Frequency: \_\_\_\_\_

**Briefly describe reason for your visit today:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List all your medical problems: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PATIENTS PERSONAL HISTORY**

List previous surgeries that you have had: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name any drugs to which you are allergic to: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

PLEASE LIST ALL MEDICATIONS YOU ARE PRESENTLY TAKING (Include all over-the-counter or non-prescription)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Pharmacy Phone #: \_\_\_\_\_

List all doctors you are currently seeing: \_\_\_\_\_

\_\_\_\_\_

**REVIEW OF SYSTEMS**

**GI:**

Rectal Bleeding YES NO  
Black Stools YES NO  
Change in Bowel Habits YES NO  
Abdominal Pain YES NO  
Loss of Appetite YES NO  
Heartburn YES NO  
Nausea/Vomiting YES NO  
Regurgitation YES NO  
Trouble Swallowing YES NO

**CVS:**

Chest Pain YES NO  
Heart Attack YES NO  
Palpitations YES NO  
Valve Replacement YES NO

**RS:**

Shortness of Breath YES NO  
Wheezing YES NO  
Cough-(Blood in Sputum) YES NO  
Hoarseness of Voice YES NO

**CNS:**

Previous Stroke YES NO  
Weakness YES NO  
Seizures YES NO  
Fainting Attacks YES NO  
Headache YES NO

**OTHER:**

Kidney Failure YES NO  
Trouble with Urination YES NO

HAVE YOU HAD A COLONOSCOPY? \_\_\_\_\_ IF SO, WHEN? \_\_\_\_\_

HAVE YOU HAD AN UPPER ENDOSCOPY? \_\_\_\_\_ IF SO, WHEN? \_\_\_\_\_

**CENTER FOR DIGESTIVE CARE, INC**  
**A Division of West Central Gastroenterology, LLP**

**Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations**

I understand that as part of my health care, Center For Digestive Care, INC. a Division of West Central Gastroenterology, LLP. Originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party-payer can verify that services billed were actually provided, and
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I have been provided with a **Notice of Information Practices** that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

**Restrictions:**

I request the following restrictions to the use or disclosure of my health information:

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May discuss treatment, payment or healthcare operations with the following persons:

(Please check all that apply)    Spouse [  ]    Your Children [  ]    Relatives [  ]    Others [  ]    Parents [  ]

Please list the names and relationship, if you checked "Relatives" or "Others" above

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**Messages or Appointment Reminders: (Please check all that apply)**

May we leave a message on your answering machine at home [  ] or at work [  ]. Do not leave a message [  ]  
May we leave a message with someone at your home using the doctor's name or the practice name: Yes [  ] No [  ]  
May we leave a message with someone at your work using the doctor's name or the practice name: Yes [  ] No [  ]  
Messages will be of a non-sensitive nature, such as, appointment reminders.

I understand that as part of treatment, payment, or health care operations, it may become necessary to disclose health information to another entity, i.e., referrals to other healthcare providers, labs, and/or other individuals or agencies as permitted or required by state or federal law.

**I fully understand and accept the information provided by this consent.**

\_\_\_\_\_  
Patient's Signature (or authorized representative signing for patient)

\_\_\_\_\_  
Date

\*If other than patient is signing, are you the parent, legal guardian, custodian or have Power of Attorney for this patient, for treatment, payment or healthcare operations. Yes [  ] No [  ]

**FOR OFFICE USE ONLY**

[  ] Patient refused to sign the consent form.

[  ] Consent received by \_\_\_\_\_ on (date) \_\_\_\_\_.

[ ] Consent refused by patient, treatment refused as permitted.

**CENTER FOR DIGESTIVE CARE, INC**  
**A Division of West Central Gastroenterology, LLP**

**CANCELLATION POLICY FOR OUT PATIENT PROCEDURES**  
**PLEASE READ, SIGN AND DATE**

If you cancel your procedure once it is scheduled or you do not show up for your procedure without notifying us, you will have to wait for the doctor's next available appointment, which could be up to 3 months from now. If you cancel your procedure a second time you must come in for a visit with the physician before we will reschedule you. **Also, there will be a cancellation fee of \$100 for any procedure that is cancelled without a **ten (10) business days notice.**** The physicians have limited outpatient time and there are other patients that could be scheduled in your place.

Please do not schedule your procedure unless you are sure the procedure date fits into your schedule.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

By signing you are agreeing to this policy.