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 heath 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:

_____

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

_____

_____

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.