Gastrointestinal Specialists P.C.

Name: _____ SSN: _____
LAST FIRST MIDDLE INT

Birth date: _____ Age: _____ Sex: M F Marital Status: S M W D

Race: please circle: American Indian, Asian, African American, Caucasian, Declined

Preferred Language: _____

Ethnicity: Please circle: Hispanic or Latino, not Hispanic or Latino, Unknown, Declined

Address: _____
STREET CITY ST ZIP CODE

Home Phone #: ( ) _____ E-Mail Address: _____

Work Phone #: ( ) _____ Cell Phone #: ( ) _____

Employer: _____ Employer address: _____

If you were referred by a Physician please list their name and address below.

_____
REFERRING DOCTOR ADDRESS

Please list Primary Care Physician below: (If different from above)

_____
PRIMARY DOCTOR ADDRESS

PRIMARY INSURANCE: _____ Subscriber Name _____ Date of Birth _____

Employer Name: _____ Employer Address _____
CITY ST ZIP CODE

Relation to insured: Self Spouse Child

Insured's ID Number _____ Group # _____

SECONDARY INSURANCE: _____ Subscriber Name _____ Date of Birth _____

Employer Name _____ Employer Address _____
CITY ST ZIP CODE

Relation to Insured Self Spouse Child

Insured's ID Number _____ Group # _____

OFFICE POLICY REGARDING INSURANCE: Your insurance is a method of reimbursement to you for professional expenses paid to the physician and is not a substitute for payment. Some companies pay fixed amounts for certain procedures and others pay a percentage of the charge. You will be responsible for any deductibles, co-payments, or other balances not paid by your insurance, including no call/no show fees without 24 hour notification to cancel/change appointment.

IT IS EXPECTED THAT CHARGES FOR OFFICE VISITS WILL BE PAID AT THE CONCLUSION OF EACH OFFICE VISIT.

AUTHORIZATION FOR DIRECT BILLING: I hereby assign all medical and/or surgical benefits, including major medical benefits (Medicare, private insurance, and other health insurances) to Gastrointestinal Specialists PC. This assignment will remain in effect until revoked by me in writing. A photocopy is considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize assignee to release information in my medical record to third party payers to secure payment for services rendered.

SIGNED _____ DATE _____

RESPONSIBLE PARTY _____ DATE _____

GASTROINTESTINAL SPECIALISTS, P.C.

Gastroenterology, Hepatology and Therapeutic Endoscopy

MICHAEL C. DUFFY, M.D., F.A.C.P., F.A.C.G.
ATULKUMAR S. PATEL, M.D., F.A.C.P., FA.C.G.
GREGORY W. KULESZA, M.D.
MICHAEL E. CANNON, M.D., F.A.C.P.
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MARYCONI JACOB, M.D.
KETAN RANA M.D.

264 W. MAPLE ROAD,
SUITE 200
TROY, MI 48084-5435
(248) 273-9930
FAX: (248) 273-9931
www.gidrs.com

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____ authorize **William Beaumont Hospital** to release the following medical information to **Gastrointestinal Specialists, P.C.**

_____

_____

_____

_____

_____

_____

This release also specifically allows the release of the following information (this information will not be released if the appropriate box is initialed.)

_____ Any record of treatment for Drug and / or Alcohol dependency or abuse.

_____ Any record of Mental Health Treatment.

_____ Any record of testing, care, treatment, reporting or research pertaining to infection of HIV or related diseases.

_____ (Specify) _____

This information is being released for the following purpose only: **continuation of care** and may not be used for any other purpose or released to any other person(s) without my written consent.

S/_____ Date _____

Patient / legal Guardian of Patient

Social Security Number_____

Birthdate_____

S/_____

Witness

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Alcohol/Tobacco Questionnaire

Patient Name: _____ **Date:** _____

1) **How often do you have a drink containing alcohol?**
   - o Never
   - o Monthly or less
   - o 2-4 times a month
   - o 2-3 times a week
   - o 4 or more times a week
2) **How many standard drinks containing alcohol do you have on a typical day?**
   - o 0
   - o 1 or 2
   - o 3 or 4
   - o 5 or 6
   - o 7 to 9
   - o 10 or more
3) **How often do you have six or more drinks on one occasion?**
   - o Never
   - o Less than monthly
   - o Weekly
   - o Daily or almost daily
4) **Do you smoke regularly?**
   - o No
   - o Yes- How many years? _____ How many daily? _____
   - o Cigarettes Cigars Pipes
5) **Have you every smoked?**
   - o No
   - o Yes- How many per day? ___ How long? _____When stopped? ____
   - o

Alcohol Cessation Literature given: ☐ Tobacco Cessation Literature Given: ☐

Patient Signature:_____ **Physician Signature:**_____

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HIPAA Authorization

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that the communicator of PHI be made by alternative means, such as correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone ( ) _____
- o OK to leave detailed message
- o Leave message with call back number only

☐ Work Telephone ( ) _____
- o OK to leave detailed message
- o Leave message with call back number only

☐ Written Communication
- o OK to mail to my home address
- o OK to mail to my work/office address
- o OK to fax information to ( ) _____

☐ Other _____

_____

Also, to give information to spouses, significant others, and to parents/children, or guardians, we must have written permission. Please state who it is OK to give your personal health information to:

Name	Relationship
_____	_____
_____	_____
_____	_____

Signature _____ Printed Name _____

Date _____/_____/_____ Patient Birthdate _____/_____/_____

☐ Please check if you **DO NOT** want a copy of the Notice of Privacy Disclosure.

gastrointestinal
specialists, pc
&
endoscopy center

Patient Name/#_____

Date_____

Covid 19- Screening Form

1. Have you experienced any of the following symptoms in the past 48 hours:

- fever or chills
- cough
- shortness of breath or difficulty breathing
- fatigue
- muscle or body aches
- headache
- new loss of taste or smell
- sore throat
- congestion or runny nose
- nausea or vomiting
- diarrhea

Yes No

Answering "yes" to any of the above symptom's questions may result in a referral to a primary care provider for assessment and possible testing.

2. Are you fully vaccinated?

Yes No

To be considered fully vaccinated, you must be ≥2 weeks following receipt of the second dose in a 2-dose series or ≥2 weeks following receipt of one dose of a single-dose vaccine

3. Have you recovered from a documented COVID-19 infection in the last 3 months?

Yes No.

4. Have you been in close physical contact in the last 14 days with: • Anyone who is known to have laboratory-confirmed COVID-19? OR • Anyone who has any symptoms consistent with COVID-19?

Yes No

Close physical contact is defined as being within 6 feet of an infected/symptomatic person for a cumulative total of 15 minutes or more over a 24-hour period,starting from 48 hours before illness onset

5. Are you currently waiting on the results of a COVID-19 test?

Yes No

6. Have you traveled in the past 10 days?

Yes No

PATIENT'S PERSONAL HISTORY

Date _____ **Patient Number** _____

Confidential Record: *Information contained here will not be released except when you have authorized us to do so.*

Last Name	First	Middle	Birth Date	Birth Place

Address	City/State/ZIP	Home Phone	Business Phone

Occupation _____

Insurance Company _____ Insurance No. _____

Social Secruity Number	Sex M F	Marital Status	Religion (optional)

Person to Notify for Emergency _____ Relationship to Patient _____

Address _____ Phone Number _____

Family History	IF LIVING		IF DECEASED	
	AGE	HEALTH	AGE AT DEATH	CAUSE
Father				
Mother				

Brothers/Sisters *(Please circle sex since some names may be used for either man or women)*

M F				
M F				
M F				
M F				
M F				

Sons/Daughters *(Please circle sex since some names may be used for either man or women)*

M F				
M F				
M F				
M F				
M F				

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

Colon polyps _____ Pancreatitis _____ Ulcerative colitis _____

Colon cancer _____ Liver disease _____ Peptic Ulcer _____

Other cancer _____ Crohn's disease _____ Celiac disease _____

Gallbladder Disease _____

Other: _____

Personal Habits: *(Circle yes or no)*

YES NO Do you smoke regularly? Cigarettes ____ Pipe ____ Cigars ____ How many years? _____ How many daily? _____

YES NO Did you smoke? How many? _____ How long? _____ When stopped? _____

YES NO Do you drink over 3 cups of coffee per day?

YES NO Do you drink alcohol regularly? How much per day? _____ For how long? _____

YES NO Did you drink alcohol in the past? How much per day? _____ For how long? _____ When stopped? _____

YES NO Spells of dizziness? *YES NO* Do you frequently have hoarseness?

YES NO Have you ever had convulsions/seizures?

YES NO Have you ever had shortness of breath? ***(If yes, answer the following):***

YES NO Doing your usual work? *YES NO* Which awakens you at night?

YES NO Climbing a flight of stairs? *YES NO* Do you have a chronic cough?

MEDICATIONS:

Please list all your medications by name, dose, frequency taken and when started.

	NAME	DOSE	FREQUENCY	STARTED
1.				
2.				
3.				
4.				
5.				

6. Other: Aspirin/pain medication: _____

7. Over the counter/herbal medications: _____

Name any drugs to which you are allergic:

	NAME	REACTION
1.		
2.		
3.		

Write in the names and years of any operations which you have had:

_____

_____

_____

Write in the names and dates of any illnesses you have had which <u>required hospitalization</u>:

_____

_____

_____

Do you have the following: *(Circle and briefly describe)*

Hypertension _____ Bleeding Problems _____

Diabetes _____ Sedation Problems _____

Lung Problems _____ Sleep Apnea _____

Liver Problems _____ Anesthesia Problems _____

Kidney Problems _____ Heart Attack _____

Cancer _____

Blood or blood product transfusion prior to 1992? _____

_____

_____

Serious injuries or accidents:

_____

_____

_____

_____

Do you have a history of mitral valve prolapse, other heart valve problems, artificial heart valve, history of endocarditis (heart infection), artificial joints or shunts? Do you have a pacemaker or cardiac defibillator?

_____

_____

_____

_____

Are you required to take antibiotics prior to any dental or medical procedure? Why?

_____

_____

YES NO Have you ever had pain or tightness in the chest? ***(If yes, answer the following)*** *which begins when...*

YES NO When exerting yourself?
YES NO When walking up a hill or stairs?
YES NO After a heavy meal?
YES NO Palpitations

YES NO Have you had angina, heart failure or heartbeat irregularity?

YES NO Have you recently had pain in the stomach? ***(If yes, answer the following)*** *which...*

YES NO Occurs while eating or immediately after?
YES NO Occurs 1-2 hours after a meal?
YES NO Is brought on by eating fried or gassy foods?
YES NO Is relieved with milk or eating?
YES NO Awakens you at night?
YES NO Is relieved by antacid medications?
YES NO Do you frequently have trouble swallowing?
YES NO Do you frequently have nausea and vomiting?

If you have had a change in bowel habit recently, answer the following: *(Circle yes or no)*

WHEN OR SINCE WHEN?

YES NO Crampy pain in the abdomen?
YES NO Alternating diarrhea and constipation?
YES NO Pain during or after bowel movement?
YES NO Mucous in the stool?
YES NO Blood in the stool?
YES NO Ribbon-like stools?
YES NO Black stools?
YES NO Require use of strong laxatives or enemas?
YES NO Stool leakage?

Have you had: *(Circle yes or no)*

WHEN OR SINCE WHEN?

YES NO Peptic ulcer disease?
YES NO Gallbladder disease?
YES NO Hiatal hernia?
YES NO Pancreas problems?
YES NO Crohn's disease?
YES NO Ulcerative colitis?
YES NO Lactose intolerance?
YES NO Polyps?
YES NO Cancer?
YES NO GI surgery?
YES NO Hernia?
YES NO GI x-rays, endoscopy, CT scan or ultrasound study?
If so, where?

Have you had: *(Circle yes or no)*

WHEN OR SINCE WHEN?

YES NO Burning when urinating?
YES NO Loss of bladder control?
YES NO Blood in urine?
YES NO Dark colored urine?
YES NO Getting up frequently at night?
YES NO Passed a kidney stone?

Have you recently had: *(Circle yes or no)*

WHEN OR SINCE WHEN?

YES NO Circulation problems?
YES NO Arthritis?
YES NO Swelling in the ankles?

Describe briefly your present medical symptoms: