gi DOCTORS

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PATIENT INFORMATION

Name *(Last, First, M.I.):* ☐ M ☐ F		**DOB:**
Address		**City & Zip**
Email Address:		**SS #**
Home Phone	**Cell/Work Phone**	**Preferred:** ☐ Home Phone ☐ Cell Phone
Pharmacy *(Name & Address)*		**Pharmacy Phone**
Employer *(Name & Address)*		**Employer Phone**
Emergency Contact *(Name & Address)*		**Emergency Contact Phone**
Primary Language	**Race** ☐ Caucasian ☐ African American ☐ Asian ☐ Hispanic ☐ Other:	
Occupation	**Marital Status** ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Other:	
Primary Doctor *(Name & Address)*		**Primary Doctor Phone Number**

INSURANCE INFORMATION

Primary Insurance	**Policy Number**	**Policy Group**
Primary Policy Holders Name		
Secondary Insurance	**Policy Number**	**Policy Group**
Secondary Policy Holders Name		

BENEFIT ASSIGNMENT / RELEASE OF INFORMATION

I, assign all medical and/or surgical benefits from Medicare, Private Insurance Carrier(s), and any other health plan coverage to which I am entitled to Chris Demetriou MD P.C., to receive payment for their services. A photo copy or facsimile of this assignment is to be considered as valid as the original. I, authorize Chris Demetriou MD P.C. to release all information necessary, including Medical Records, to secure such payment. I certify that the information given by me in applying for payment is correct. I understand that I am financially responsible for any balance not covered by my insurance.

Patient Signature	**Date**

PATIENT HIPAA CONSENT FORM

Our Notice of Privacy practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under the law. You have the right to review our notice before signing this consent. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
The patient understands that:

1. Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
2. The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
3. The patient may revoke this consent in writing at any time and all future disclosures will then cease.
4. I understand that at times I may be notified of test results by phone

Check All That Apply
☐ I allow my doctor's office to leave messages on my home or cell phone
☐ I allow my doctor's office to leave a message with the following specified family members (Please list):

Patient Signature	**Date**

Reason for seeing the gastroenterologist:

Who Referred You:

Have you experienced any of the following?

☐ Difficulty Swallowing	☐ Pain on Swallowing	☐ Heartburn/ Reflux	☐ Excessive Belching	☐ Getting Full easily
☐ Hx of Colon Polyps	☐ Hx of Colon Cancer	☐ Bloating	☐ Excessive Gas	☐ Hx of Barrets
☐ Weight Loss	☐ Change In Appetite	☐ Blood in the Stool	☐ Change in caliber of stool	☐ Change in color of stool
☐ Anemia	☐ Shortness of Breath	☐ Gall stones	☐ Abdominal Pain	☐ Chest Pain
☐ Diarrhea	☐ Constipation	☐ Diverticular Disease	☐ Gallstones	☐ Gall bladder Polyps
☐ Nausea and/or Vomiting	☐ Pancreatitis	☐ Irritable Bowel Syndrome	☐ Crohns Disease	☐ Ulcerative Colitis
☐ Emphysema	☐ Sleep Apnea	☐ Ulcers	☐ Hepatitis	☐ Fatty Liver
☐ Asthma	☐ Heart Attack	☐ High Blood Pressure	☐ High Cholesterol	☐ Rheumatic Disease
☐ Heart Failure	☐ Kidney Disorder	☐ Heart Murmur	☐ Anxiety	☐ Depression
☐ Autoimmune Disease	☐ Seizure Disorder	☐ Irregular Heart Beat	☐ Diabetes	☐ Thyroid Disease
☐ Other:		☐ Stroke / TIA	☐ Skin Disease or Rashes	☐ Vision Problems

Medical History:

Surgical History:

Allergies:
Including Drugs, Food, Radiologic Contrast

Medications: *List your prescribed drugs and over-the-counter drugs including NSAIDs, other pain meds, vitamins & supplements*

Name of the Drug	Dosage / Frequency Taken	Prescribed/Recommended by

Hospitalizations

Year	Reason	Hospital

Smoking History ☐ Never Smoker ☐ Quit ☐ Current: Packs per day:

Alcohol: ☐ Never ☐ Former ☐ Current: drinks per week:

History of Drug Use:

Do You have any Tattoos: ☐ Yes ☐ No

Have you ever had a Flu Shot? ☐ Yes ☐ No ☐ Refused
If Yes, Please Specify Date

Have you ever had an Pneumonia shot? ☐ Yes ☐ No ☐ Refused
If Yes, Please Specify Date

Have you ever had a COLONOSCOPY? ☐ Yes ☐ No
If Yes, Please Specify Date

Have you ever had an ENDOSCOPY? ☐ Yes ☐ No
If Yes, Please Specify Date

FAMILY HISTORY
Please list the ages of your parents, siblings, and grandparents and record any medical problems including Stomach/Esophageal/Pancreatic/Liver/Colon Cancer, Barrets Esophagus, or any other Liver diseases including Cirrhosis

Family Member	Medical Problem