Patient Registration Form

Digestive Health Specialists, P.A

Patient Information

Patient Information

Last Name:	First Name	M.I.:	Previous Name (if applicable)

Mailing Address: Apt #

City/State/Zip:

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widow	Sex: ❑ Male ❑ Female	Social Security #:

Cell Phone:	Home Phone:	Email:

Preferred Method of Contact for Reminder Calls and Other Electronically Generated Messages:
(Please Select Only One Option) ❑ Voice ❑ Text

If Voice, Please Select Preferred Number: ❑ Home ❑ Cell

Employer Name: Employer Phone Number:

Emergency Contact Name:

Emergency Contact Phone #: Relationship to Patient:

Race (please select):
❑ White ❑ American Indian or Alaska Native ❑ Asian
❑ Hispanic ❑ Black or African American ❑ Native Hawaiian or Pacific Islander
❑ Other ❑ Decline

Ethnicity (please select one):
❑ Hispanic or Latino
❑ Not Hispanic or Latino
❑ Decline

Preferred Language (please select one): ❑ English ❑ Spanish ❑ Chinese ❑ Sign Language ❑ Japanese ❑ Other

Preferred Pharmacy Name, Location & Phone Number:

Insurance Information

Primary Medical Insurance	**Secondary Medical Insurance**
Ins. Co. Name:	Ins. Co. Name:
Policy Holder Name:	Policy Holder Name:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

Responsible Party

Responsible Party - If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor.

Last Name:	First Name:

Date of Birth:	Social Security #:	Phone:

Address of Person Responsible:

City/State/Zip:	Relationship to Patient:

I certify that I have read and agree to Digestive Health Specialists' (DHS) payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to DHS all money to which I am entitled for medical expenses related to the services performed from time to time by DHS, but not to exceed my indebtedness to DHS. I authorize DHS to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $30.00 returned check fee will be charged for checks returned due to insufficient funds. I choose to receive communications from DHS by text or e-mail at the number or address stated above, including but not limited to communications about appointments, treatment, and payment. I understand that such e-mails and texts may not be secure and there is a risk that they may be read by a third party.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to DHS. I authorize any holder of medical information about me to release to DHS and its agents any information needed to determine these benefits or the benefits payable for related services.

I have reviewed a copy of Digestive Health Specialists' Privacy Notice. ☐ **(Initials)**

Signature of Patient or Responsible Party: **X**_____ **Date:**_____

Printed Name of Patient or Responsible Party: **X**_____ **Date:**_____

DIGESTIVE HEALTH SPECIALISTS
PATIENT HISTORY FORM

Instructions: Complete the following information as best as possible.
Do NOT write in areas labeled "For Medical Team Use Only"

Patient Name: _____ Sex: ☐ Male ☐ Female Date of Birth: _____
(last) (first) (M.I.)

Today's Date: _____ Who Completed This Form ☐ Patient ☐ Spouse ☐ Other _____

Who is your referring doctor? Name _____

Chief Complaint

Why are you seeing the Doctor? _____

DO YOU HAVE ANY OF THE FOLLOWING?

Esop/Gastric	YES	NO	Describe the problem when appropriate
Chest Pain	☐	☐	
Heartburn	☐	☐	
Acid Reflux	☐	☐	
Difficulty Swallowing	☐	☐	
Solids	☐	☐	
Liquids	☐	☐	
Abdominal Pain	☐	☐	Location:
Loss of appetite	☐	☐	
Nausea	☐	☐	
Vomiting	☐	☐	
Vomiting Blood	☐	☐	
Weight loss	☐	☐	How much? _____ Over how long? _____
Bloating	☐	☐	
Belching	☐	☐	

Intestinal			
Heme + Stool	☐	☐	
Rectal Bleeding	☐	☐	
Rectal Pain	☐	☐	
Hemorrhoids	☐	☐	
Anal Fissure	☐	☐	
Diverticulosis	☐	☐	
Constipation	☐	☐	
Diarrhea	☐	☐	
Black, Tarry Stools	☐	☐	
Stool Incontinence	☐	☐	
Bowel Habit Change	☐	☐	
Light color stool	☐	☐	

GI History			
Anemia	☐	☐	Type:
Hepatitis	☐	☐	Type:
Blood Transfusion	☐	☐	Date:
Cirrhosis	☐	☐	Type:
Hemochromatosis	☐	☐	
Pancreatitis	☐	☐	Type:
Pancreatic Cancer	☐	☐	
Ulcers	☐	☐	
Barrett's Esophagus	☐	☐	
Chron's Disease	☐	☐	
Ulcerative Colitis	☐	☐	
Irritable Bowel	☐	☐	
(+) H Pylori	☐	☐	Treated? _____ Eradicated? _____
Colon Cancer	☐	☐	Family ? Yes ☐ No ☐
Colon Polyps	☐	☐	Family? Yes ☐ No ☐

Medications- (list any Medicines that you are currently taking)

Name of Medicine	Dosage	How Often

Allergies- (list any Medicines that you are allergic to)

Allergy	Reaction

Past Illness/Disease	Year	**Past Surgeries**	Year

Past Procedures	Yes	No	
EGD	☐	☐	Date of Last Procedure:_____
ERCP	☐	☐	Date of Last Procedure:_____
Colonoscopy	☐	☐	Date of Last Procedure:_____
Flexible Sigmoid	☐	☐	Date of Last Procedure:_____
Other_____			Date of Last Procedure:_____

Family History

	Father	Mother	Brother	Sister	Grand parent	Son	Daughter	Other	None
Breast Cancer									
Diabetes									
Gastric Cancer									
Heart Disease									
Hypertension									
High Chol/Trig									
Liver Disease									
Pancreatic Cancer									
Peptic Ulcer Disease									
Prostate Cancer									
Stroke									
Alcohol Abuse									

Family History Continued:

Father
◯ Alive ◯ Deceased
Age at death: _____
Cause of death: _____

Mother
◯ Alive ◯ Deceased
Age at death: _____
Cause of death: _____

Personal History

Diet: ◯ Regular ◯ Soft ◯ Diabetic ◯ Heart ◯ Other _____
Marital Status: ◉ Married ◯ Single ◯ Divorced ◯ Widowed ◯ Separated
Work Status: ◯ Disabled ◯ Does Not Work ◯ Employed Full Time ◯ Employed Part Time
◯ Homemaker ◯ Self Employed ◯ Retired ◯ Student ◯ _____
Employer: _____
Language: ◯ English ◯ Spanish ◯ French ◯ Mute
Tattoos: ◯ Yes ◯ No
Body Piercing: ◯ Yes ◯ No

Any religious or cultural practices that we should be aware of? ◯ Yes ◯ No If yes, explain._____
Preferred method of contact: ◯ Secure Message ◯ Mail ◯ Cell Phone ◯ Home Phone
Are you at increased risk for hepatitis by the following lifestyles? ◯ Yes ◯ No
◯ Homosexuality ◯ Bisexuality ◯ Multiple Sex Partners

Health Habits

Smoke: ◯ Never ◯ Current ◯ Past
How many packs, cigars or pipes per day? _____ Years smoked: _____ Year quit: _____
Chewing Tobacco: ◯ Yes ◯ No # Years used _____ Year quit: _____
Passive smoke exposure: ◯ Yes ◯ No
Caffeine use: ◯ Yes ◯ No
Do you use any drugs like marijuana, cocaine, amphetamines, etc? ◯ Yes ◯ No
◯ IV drug use ◯ Marijuana use ◯ Prescription drug use ◯ _____
Seatbelt use: ◯ Yes ◯ No
Alcohol use: ◯ Current ◯ Past ◯ Never
Years Used: _____
Year Quit: _____
# of alcoholic drinks/day (on average): ◯ <1/day ◯ 1-2/day ◯ 3-4/day ◯ >5/day ◯ _____
Type of alcohol used: ◯ wine ◯ beer ◯ liquor _____

Patient Signature_____ Physician Signature_____ Date___/___/___

Current Symptoms

General
Chills
Fatigue/Weakness
Fever
Weight Loss

Eyes
Cataract
Double Vision
Glaucoma

ENT (Ear, Nose, Throat)
Decreased Hearing
Difficult Swallowing
solids
liquids
Hoarseness
Painful swallowing
Sore throat

Cardiovascular (Heart)
Chest Pains
Heart Failure
Rapid Heart Beat
Swelling of feet/ankles

Respiratory
Asthma
Cough
Shortness of breath

Genitourinary
Dark urine
Frequent urination
Loss of bladder control
Painful urination
Urinate Air

Musculoskeletal
Back pain
Joint pain
Muscle cramps

Dermatology (skin)
Change in Mole
Itching
Jaundice
Rash
Sores
Suspicious Lesions

Neurological
Dizziness
Forgetfulness
Frequent Headaches
Loss of Consciousness
Problem maintaining train of thought
Seizures
Stroke

Psychiatric
Anxiety
Change in energy level
Confusion
Depression
Difficulty sleeping

Endocrine
Cold intolerance
Diabetes
Heat intolerance
High cholesterol
Thyroid Disorder

Hematology
Anemia
Bruise or bleed easily
Blood clotting disorder

Allergy
Urticaria (itchy skin)
Allergic Rash
Hay Fever
Recurrent Infections