

## Patient Registration

**PATIENT INFORMATION - the person being seen by the doctor**

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Last Name \_\_\_\_\_ First \_\_\_\_\_ Initial \_\_\_\_\_  
 Home Address \_\_\_\_\_ Zip \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
 Mailing address \_\_\_\_\_ Zip \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell or Pager \_\_\_\_\_ Referring Doctor \_\_\_\_\_  
 Patient's Relationship to Policyholder 1 – Spouse 2 – Child 3 – Other  
 Date of Birth \_\_\_\_\_ Patient Sex \_\_\_\_\_ Male \_\_\_\_\_ Female  
 Patient's Marital Status: (circle one) 1- Married 2-Single 5-Widowed 4-Other 6- Legally Separated 7-Divorced  
 Patient's Social Security \_\_\_\_\_  
 Patient's Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
 Address \_\_\_\_\_ Zip \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Phone \_\_\_\_\_

**GUARANTOR INFORMATION - the person who carries the insurance policy or is responsible for payment**

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Last Name \_\_\_\_\_ First \_\_\_\_\_ Initial \_\_\_\_\_  
 Home Address \_\_\_\_\_ Zip \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell or Pager \_\_\_\_\_ Email Address \_\_\_\_\_  
 Social Security \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Mailing address \_\_\_\_\_ Zip \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
 Guarantor Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
 Address \_\_\_\_\_ Zip \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Phone \_\_\_\_\_  
  
 Primary Insurance \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_  
 Secondary Insurance \_\_\_\_\_ ID# \_\_\_\_\_ Group# \_\_\_\_\_  
 Guarantor for Secondary? \_\_\_\_\_ Social Security \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Mobile Phone \_\_\_\_\_

Emergency Contact- please provide a phone number other than your home

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Do you have an advanced directive for Healthcare (living will or medical Power of Attorney)?

If yes, we are required to have a copy on file. \_\_\_\_\_ Copy Received \_\_\_\_\_ Copy Requested

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I authorize release of any medical information necessary to process Medicare and/or any insurance claims. I authorize payment of medical benefits to Digestive Healthcare Associates, LLC. I understand I am responsible for any deductibles, co-payments, co-insurance or amounts not covered by the Insurance carrier. In the event that my account is assigned to a collection agency, I agree to pay an additional collection fee of 25% of the outstanding balance assigned to the collection agency. I also agree to pay any interest on the principal balance, court cost and attorney fees associated with the collection of my account. **In addition, I am aware that if I cannot attend a scheduled appointment I must call at least 24 hours in advance to avoid a \$20 no show fee.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Initials

## Patient Intake Form

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Who is your primary doctor? \_\_\_\_\_ Referring Physician? \_\_\_\_\_

Reason for seeing a Gastroenterologist: \_\_\_\_\_ Email: \_\_\_\_\_

Have you had a \_\_\_\_\_ Colonoscopy or \_\_\_\_\_ Sigmoidoscopy done in the past 10 years?    Yes    No  
 If yes, what year was it performed? \_\_\_\_\_ Anything found? \_\_\_\_\_

Have you had an Upper Endoscopy done in the past 10 years?    Yes    No  
 If yes, what year was it performed? \_\_\_\_\_ Anything found? \_\_\_\_\_

Has anyone in your immediate family been diagnosed with colon cancer or polyps?    Yes    No  
 If yes, please explain: \_\_\_\_\_

**CURRENT SYMPTOMS:** (check all that apply)

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Abdominal pain   | <input type="checkbox"/> Change in bowel habits | <input type="checkbox"/> Black, tarry stool    | <input type="checkbox"/> Food sticking in esophagus |
| <input type="checkbox"/> Nausea           | <input type="checkbox"/> Diarrhea               | <input type="checkbox"/> Gas / bloating        | <input type="checkbox"/> Painful swallowing         |
| <input type="checkbox"/> Vomiting         | <input type="checkbox"/> Constipation           | <input type="checkbox"/> Heartburn             | <input type="checkbox"/> Jaundice                   |
| <input type="checkbox"/> Bloody vomiting  | <input type="checkbox"/> Rectal bleeding        | <input type="checkbox"/> Acid reflux           | <input type="checkbox"/> Abnormal liver tests       |
| <input type="checkbox"/> Fevers           | <input type="checkbox"/> Blood in stool         | <input type="checkbox"/> Belching/Burping      | <input type="checkbox"/> Anemia                     |
| <input type="checkbox"/> Chills           | <input type="checkbox"/> Blood on toilet paper  | <input type="checkbox"/> Indigestion           | <input type="checkbox"/> Stool incontinence         |
| <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Hemorrhoids            | <input type="checkbox"/> Lactose intolerance   |   |
| <input type="checkbox"/> Weight loss      | <input type="checkbox"/> Anal pain              | <input type="checkbox"/> Difficulty swallowing |   |

**PAST MEDICAL/SURGICAL HISTORY** (check all that apply)

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> None                       | <input type="checkbox"/> Emphysema/COPD      | <input type="checkbox"/> Hemophilia               | <input type="checkbox"/> Fatty liver      |
| <input type="checkbox"/> High Blood Pressure        | <input type="checkbox"/> Valley Fever        | <input type="checkbox"/> GERD/Acid Reflux         | <input type="checkbox"/> Diverticulosis   |
| <input type="checkbox"/> Heart Attack/MI            | <input type="checkbox"/> Tuberculosis        | <input type="checkbox"/> Barrett's Esophagus      | <input type="checkbox"/> Diverticulitis   |
| <input type="checkbox"/> Heart Disease/Stents       | <input type="checkbox"/> Sleep Apnea         | <input type="checkbox"/> Hiatal Hernia            | <input type="checkbox"/> Anemia           |
| <input type="checkbox"/> Elevated Cholesterol       | <input type="checkbox"/> Lung Clots          | <input type="checkbox"/> Stomach / Duodenal Ulcer | <input type="checkbox"/> Depression       |
| <input type="checkbox"/> Heart Valve Problem/Murmur | <input type="checkbox"/> Diabetes Mellitus   | <input type="checkbox"/> Celiac Disease           | <input type="checkbox"/> Anxiety Disorder |
| <input type="checkbox"/> Congestive Heart Failure   | <input type="checkbox"/> Seizure Disorder    | <input type="checkbox"/> Helicobacter Pylori      | <input type="checkbox"/> Bipolar Disorder |
| <input type="checkbox"/> Atrial Fibrillation        | <input type="checkbox"/> Stroke/TIA          | <input type="checkbox"/> Irritable Bowel (IBS)    | <input type="checkbox"/> Schizophrenia    |
| <input type="checkbox"/> Heart Arrhythmia           | <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Crohn's Disease          | <input type="checkbox"/> Arthritis        |
| <input type="checkbox"/> Blood Transfusions         | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Ulcerative Colitis       | <input type="checkbox"/> Osteoporosis     |
| <input type="checkbox"/> Pacemaker/Defibrillator    | <input type="checkbox"/> Thyroid Disease     | <input type="checkbox"/> Pancreatitis             | <input type="checkbox"/> Fibromyalgia     |
| <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Bleeding Disorder   | <input type="checkbox"/> Hepatitis                | <input type="checkbox"/> HIV/AIDS         |
| <input type="checkbox"/> Lupus                      | <input type="checkbox"/> Kidney problems     | <input type="checkbox"/> Hemodialysis             | <input type="checkbox"/> Liver Cirrhosis  |
| <input type="checkbox"/> Cancer, type(s): _____     |  |   |   |

**PAST SURGICAL HISTORY** (check all that apply)

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> None                     | <input type="checkbox"/> Tubaligation           | <input type="checkbox"/> Stomach ulcer surgery   | <input type="checkbox"/> Rectal prolapse surgery        |
| <input type="checkbox"/> Removal of tonsils       | <input type="checkbox"/> C-section              | <input type="checkbox"/> Hemorrhoidectomy        | <input type="checkbox"/> Coronary bypass                |
| <input type="checkbox"/> Removal of gallbladder   | <input type="checkbox"/> Prostate surgery       | <input type="checkbox"/> Inguinal hernia repair  | <input type="checkbox"/> Heart valve replacement        |
| <input type="checkbox"/> Removal of appendix      | <input type="checkbox"/> Thyroid surgery        | <input type="checkbox"/> Abdominal hernia repair | <input type="checkbox"/> Pacemaker placement            |
| <input type="checkbox"/> Hiatal hernia repair     | <input type="checkbox"/> Lung surgery           | <input type="checkbox"/> Total knee replacement  | <input type="checkbox"/> Defibrillator (AICD) placement |
| <input type="checkbox"/> Removal of uterus        | <input type="checkbox"/> Gastric bypass surgery | <input type="checkbox"/> Total hip replacement   |   |
| <input type="checkbox"/> Removal of ovary/ovaries | <input type="checkbox"/> Colon surgery          | <input type="checkbox"/> Bladder suspension      |   |

**PLEASE LIST OTHER MEDICAL/SURGICAL HISTORY THAT MAY HAVE NOT BEEN LISTED:**

\_\_\_\_\_

\_\_\_\_\_

**Allergies to Medicine:**

Are you allergic to any medication?      Yes      No

If yes, please name medications & reactions: \_\_\_\_\_

**Medications:**

Do you take aspirin or arthritis medication (ibuprofen, naproxen, Aleve, Motrin, Advil)?      Yes      No

If yes, please name medication & frequency: \_\_\_\_\_

Do you take blood thinners (Coumadin, Warfarin, Heparin, Lovenox, Plavix)?      Yes      No

If yes, please name medication & frequency: \_\_\_\_\_

Please list other medications you are taking (include "over-the-counter" medicine and doses if possible)

\_\_\_\_\_

\_\_\_\_\_

**Preferred Pharmacy Name:** \_\_\_\_\_ **Cross Streets:** \_\_\_\_\_

**Social History/Marital Status:**

\_\_\_ Single      \_\_\_ Married      \_\_\_ Divorced      \_\_\_ Separated      \_\_\_ Widowed

Your occupation: \_\_\_\_\_ Retired \_\_\_ Unemployed \_\_\_ Disabled \_\_\_

Do you / have you ever used tobacco? \_\_\_ Yes \_\_\_ No      Packs per day? \_\_\_\_\_ Years? \_\_\_\_\_ Date Quit? \_\_\_\_\_

Do you use alcohol? \_\_\_ Yes \_\_\_ No      \_\_\_ Beer \_\_\_ Wine \_\_\_ Liquor      How often? \_\_\_\_\_ How much? \_\_\_\_\_

Have you ever used street drugs? \_\_\_ Yes \_\_\_ No      Type \_\_\_\_\_ Last use \_\_\_\_\_

**FAMILY HISTORY**

Does anyone in **YOUR FAMILY** have the following illnesses? Check all that apply and write in the relationship of family member, ie. Mother, maternal aunt, paternal uncle, sister.

_____ Colon polyps	_____ Stomach cancer	_____ Liver cancer	_____ Ulcerative Colitis
_____ Colon cancer	_____ Small bowel cancer	_____ Pancreatic cancer	_____ Celiac Disease
_____ Rectal cancer	_____ Esophageal cancer	_____ Crohn's Disease	_____ Gallbladder Disease
_____ Uterine / Cervical cancer	_____ Skin cancer (ie. Melanoma)	_____ Other Cancer (please describe)	

**I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of her/his staff responsible for any errors or omissions that I may have made in the completion of this form.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



### **Contact Information**

I may be contacted in the following manner (circle all that apply):

-OK to leave message with detailed information:	Home	Work	Cell	No
-OK to leave call-back number only:	Home	Work	Cell	No
-OK to send mail to:	Home	Work		No
-OK to fax to:	Home	Work		No

(fax # or #'s) \_\_\_\_\_

Those who may receive information regarding me:

_____ Spouse	Name of Spouse and birthdate: _____
_____ Other	Name and birthdate: _____
_____ Other	Name and birthdate: _____

### **Acknowledgement of Receipt of Privacy Notice** *Original to be maintained in patient's permanent medical record.*

I acknowledge that the office's Notice of Privacy Practices has been made available to me.

\_\_\_\_\_  
Patient or legally authorized individual signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name if signed on behalf of the patient

\_\_\_\_\_  
Relationship (legal guardian, personal rep., etc.)

## Notification of Outpatient Practice

I understand that through Digestive Healthcare Associates, LLC, Dr. Elizabeth Cruz and Dr. J.D. Panetta have established an outpatient practice. I understand that if I were to be hospitalized for any digestive related issue (not including issues relating to procedures performed by Dr. Cruz / Dr. Panetta directly) I will be seen by the physician on call at that particular hospital and not Dr. Cruz or Dr. Panetta.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date