**CENTRAL TEXAS GASTROENTEROLOGY CONSULTANTS**

ADULT GASTROENTEROLOGY PATIENT HEALTH HISTORY

**Appointment Date _______________**
**Full Name ____________________________ Gender _____ Date of Birth _________**
**Pharmacy Preference(include location) ______________________________________**
**Primary care Physician ____________________ Referring Doctor _______________**

- **What is the reason you are seeing the doctor today? ___________________________**

- **Please briefly give any additional information related to above problem.**

- **PAST MEDICAL HISTORY**:

Have you ever been DIAGNOSED with any of the following problems? Please circle yes or no.

| | | |
|---|---|---|
| Arthritis | No | Yes |
| Asthma | No | Yes |
| Diabetes | No | Yes |
| High blood Pressure | No | Yes |
| Lung disease | No | Yes |
| Heart Attack | No | Yes |
| Coronary Artery Disease | No | Yes |
| High Cholesterol | No | Yes |
| Cancer (Type) ____________ | No | Yes |
| Kidney Disease | No | Yes |
| Liver Disease | No | Yes |
| Sleep Apnea | No | Yes |
| Thyroid Disease | No | Yes |
| Anemia | No | Yes |
| Irritable Bowel Syndrome | No | Yes |
| Lupus/Autoimmune Disease | No | Yes |
| Acid Reflux | No | Yes |
| How often? ___________________ | | |
| Peptic Ulcer Disease | No | Yes |
| H. Pylori Infection | No | Yes |
| Hepatitis Infection | No | Yes |
| Type A, B, or C | | |
| Gallstones | No | Yes |
| Diverticular Disease | No | Yes |
| Colon Polyps | No | Yes |
| Hemorrhoids | No | Yes |
| Anxiety/Depression | No | Yes |
| HIV Infection | No | Yes |
| Blood Transfusion | No | Yes |
| Approximately what year? ____________ | | |
| Pancreatic Disease | No | Yes |
| Other Medical Issues? __________________ | | |

- **SURGERIES**:

| YEAR | DESCRIPTION OR TYPE | HOSPITAL |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

- **MEDICATION ALLERGIES**:

PLEASE LIST ANYTHING YOU ARE ALLERGIC TO SUCH AS MEDICATIONS, FOODS, AND INSECT BITES, INDICATE HOW EACH AFFECTS YOU.

| ALLERGY | TYPE OF REACTION |
|---|---|
| | |
| | |
| | |

• **CURRENT MEDICATIONS**:

Please list ANY kind of medications you are taking now. This includes prescription, over-the-counter or herbal medication. Please include dosages of each medication in known.

| NAME | DOSAGE | HOW OFTEN? | NAME | DOSAGE | HOW OFTEN? |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

• **SOCIAL HISTORY**:

Occupation: ___________________________

Martial Status: Single Married

Number of Children: ______ Ages: _________

Have you ever used tobacco in any form? No Yes If yes, how many packs daily? __________

How long have you smoked? ________ If quit, how long ago? ____________________

Do you consume alcohol? No Yes If yes, what type of alcohol? ________________________

How much? _____________ How Often? ________________

Do you use drugs recreationally? No Yes

Describe your caffeine usage? None Once Daily 2-3 Drinks Per Day ?4 Drinks Per Day

• **FAMILY HISTORY**:

Please specifically mention any family history of colon cancer, colon polyps, or liver disease, as well as any major health problems and cause of death if family member no longer living. If family history is not known, please indicate below.

FATHER: __________________________________ MOTHER: __________________________

BROTHERS: ________________________________ SISTERS: ___________________________

CHILDREN: ________________________________

•**REVIEW OF SYSTEMS**:

Circle ANY of the symptoms you are having.

CONSTITUTIONAL: Fever / Weight Loss / Weight Gain

EYES: Chang in Vision / Redness / Pain

EAR/NOSE/THROAT: Sore Throat / Choking / Hoarseness / Pain

CARDIAC: Chest Pain / Palpitations

RESPIRATORY: Shortness of Breath / Wheezing / Cough

UROLOGIC: Frequency / Urgency / Pain with Urination / Blood in Urine

PSYCHIATRIC: Nervous Breakdown / Anxiety / Depression

SKIN: Rashes / Itching / Jaundice (yellow coloring) / Paleness

NEUROLOGICAL: Weakness / Headaches / Seizure / Fainting Spells

# PATIENT INFORMATION & REGISTRATION FORM

**PT ACCT: DR:**
*(for office use only)*

## PATIENT INFORMATION:

Name ______________________
Address ______________________
______________________
City, State, Zip ______________________
Phone ____________ Type ____________
Phone ____________ Type ____________
Email Address ______________________

Date of Birth ______________________
Social Security # ______________________
Marital Status: Married Single Divorced Widowed
Sex: Male Female
Employment Status: Employed Unemployed Retired
Employer ______________________
Work Phone ______________________

## PRIMARY INSURANCE:

Carrier ______________________
Insured ID # ______________________
Policy Group ______________________
Insured Name ______________________
Insured DOB ____________ SS# ____________

## SECONDARY INSURANCE:

Carrier ______________________
Insured ID # ______________________
Policy Group ______________________
Insured Name ______________________
Insured DOB ____________ SS# ____________

## SPOUSE / RESPONSIBLE PARTY:

Name ______________________
Address ______________________
City, State , Zip ______________________
Phone ____________ Type ____________

Employer ______________________
Work Phone ______________________
Emergency Contact Name ______________________
Emergency Contact Phone ______________________

**FINANCIAL AGREEMENT:**

I understand that I am responsible for deductibles, co-pays, non-covered services, coinsurance and items considered "not medically necessary" by my insurance company. I agree to pay co-payments and coinsurances as services are rendered. I understand my insurance is a contract between myself and my insurance company and Central Texas Digestive Disease will bill my insurance as a courtesy to me. The remaining balance will be taken care of within 30 days of notice from the insurance company. Although my insurance company may estimate what they may pay, it is the insurance company that makes the final determination. I agree to pay any portion of the charges not covered by insurance. If a referral and/or preauthorization are required by my insurance company, I will assist Central Texas Digestive Disease in obtaining the referral and/or preauthorization. I understand that I am ultimately responsible for any balance on my account.

**ASSIGNMENT OF BENEFITS:**

I hereby assign to Central Texas Digestive Disease such insurance benefits to which are entitled under my insurance plan(s).

**RELEASE OF INFORMATION:**

I hereby allow Central Texas Digestive Disease to furnish any information pertaining to my medical treatment to my insurance carrier, worker's compensation representative, attorney, or other providers of service as necessary to obtain payment of services and provide additional care.

**CONSENT FOR TREATMENT:**

I hereby authorize Central Texas Digestive Disease to examine, treat and perform diagnostic tests and office procedures that the provider deems necessary.

**PRIVACY PRACTICES:**

Central Texas Digestive Disease is required by law to maintain the privacy of a patient's protected health information. In addition, we are required by law to provide individual with this notice of our legal duties and privacy practices with respect to protected health information. You must list any restrictions on the release of your protected health information below.

**I am 18 years or older and authorize release of this information to my parents and/ or children: Yes No**
**Please check one: No restrictions Restrictions**______________________________

**PHYSICIAN DISCLOSURE OF OWNERSHIP:**

I, Chang /Derbes/Gray/Pham/Moore MD, may and/or have recommended that you receive medical treatment and/or services from the Central Texas Endoscopy Center, LLC and hereby inform you that I have an ownership interest in this facility. You should be aware that alternative health care facilities may be available to you. Please sign below to acknowledge your receipt and understanding of this disclosure and that you have had an opportunity to ask and receive answers to any questions you may have about this disclosure, including your options, if any, for treatment at other facilities.

I have read and agree to the Financial Agreement, Assignment of Benefits, Release of Information, Consent for Treatment, and Physician Disclosure of Ownership as listed above. My signature below indicates that I have also received a copy of the Central Texas Digestive Disease Notice of Privacy Practices and I have indicated any restrictions on my protected health information above. Scanned signatures suffice as originals.

______________________________________________

**Patient or Responsible Party Signature** **Date**

______________________________________________

**Person Signing on Behalf of Patient (Print Name)** **Relationship to Patient** **Phone Number**