DIGESTIVE HEALTH CENTER PATIENT REGISTRATION

Name _____ DOB _____
Last First MI

Address _____ City _____ State _____ Zip _____

Employer_____Marital Status _____ Social Security # _____

Primary Insurance Carrier _____ Secondary Insurance Carrier _____

Spouses Name _____ DOB _____
Last First MI

Spouses Employer _____ Spouses Social Security # _____

Please list reliable phone numbers that we may reach you on:

Home phone:_____Mobile phone:_____

Work phone: _____Alternate:_____

Contact Name:_____

I,_____hereby give my permission for the doctor or the doctor's nurse to give the results of my lab tests, x-ray reports, and any other medical information that I may need to know to the persons listed below or to leave such information on my answering machine. I also authorize these said people pick up prescriptions and/or correspondence from the office in regards to my medical care. I also give permission for you to text me on my cell phone.

_____ _____

_____ _____

ASSIGNMENT OF BENEFITS/AUTHORIZATION FOR TREATMENT: I hereby authorize treatment and authorize the provider of medical services from Digestive Health Center to release information for these services to my insurance carrier for payment. I further authorize that payment of benefits be made to the provider on my behalf or myself. I understand that I am financially responsible for all charges not covered by insurance. I AUTHORIZE THE RELEASE OF MEDICAL RECORDS INFORMATION TO OTHER PHYSICIANS OR OTHER HEALTH CARE INSTITUTIONS FOR THE PURPOSE OF CONTINUITY OF CARE.

_____**PATIENT INTIALS**

FINANCIAL POLICY-All of our providers at Digestive Health Center accept patients that have Medicare, Medicaid, Tricare, and the majority of commercial insurances. Please be aware that some services may not be covered under your insurance program, and therefore, you will be responsible for those charges. Any deductible and/or co-insurance will be due at the time of service. We do accept cash, check, major credit and debit cards.

_____**PATIENT INITALS**

In some circumstances payment plans can be made with our billing department. If lapses occur in making payments on such plans, and/or paying on balances due, our billing department will send the delinquent accounts to a collection agency. Any fees or expenses incurred as a result of sending your account to such agency will be the responsibility of the patient. There will be a $30.00 fee for a returned check.

_____PATIENT INITALS

I have read and understand the terms of the assignment of benefits/authorization for treatment, financial policy, consent form, and authorization for medical records. AUTHORIZATION EXPIRES IN ONE (1) YEAR.

_____ _____

Patient or Authorized Representative Date

_____ _____

Signature of Digestive Health Center Representative Date

1. List your allergies: _____
_____
_____

2. What is the main reason for your visit today:

_____

_____

3. Circle any surgeries/ procedures you have had:

Appendectomy	hip/knee replacement	heart valve
Hysterectomy	eye/cataract	stomach
Bowel resection	shoulder/leg/arm	ERCP/pancreatic
Egd/Colonoscopy	Brain	hernia
Tonsils/adenoids	lung	weight loss
Gallbladder	heart stents/bypass	cyst removal

4. Circle any symptoms you are experiencing today:

Nausea and vomiting	abdominal pain
Diarrhea/ constipation	sharp, dull, stabbing, burning
Rectal bleeding	upper abdomen/ lower abdomen
Hemorrhoids	constant/intermittent
Heartburn	difficulty swallowing

5. List your medications with dosage and frequency:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

6. Circle any of your own past medical history:

Reflux/ swallowing difficulty	staph infection (location) _____
Crohns disease	COPD/asthma
Ulcerative colitis	Diabetes
Barretts esophagus	Hypertension
Gallstones	Pancreatitis
Cancer _____	Hepatitis A, B, C
Heart disease	Liver disease (fatty liver, cirrhosis)
Seizures/stroke	Kidney problems (stones, failure, dialysis)
Blood clots	Brain Injury
Ulcers	Depression

7. If you are in pain today, please rate that pain intensity:

Very Mild 1 2 3 4 5 6 7 8 9 10 Extreme

8. Pertinent Family Medical History:

Mother	_____
Father	_____
Brothers	_____
Sisters	_____
Paternal Grandmother	_____
Paternal Grandfather	_____
Maternal Grandmother	_____
Maternal Grandfather	_____

Authorization to release Health Information

I understand that I have the right to request restrictions as to how my private health information may be disclosed. In my absence, I hereby authorize the release of test results and/or medical information, including billing and appointment information, to the following:

Only check those that apply. Please specify the name for the person where applicable.

Patient Name: _____ DOB: _____

_____ Spouse: _____

_____ Family Member: _____Relation: _____

_____ Family Member: _____Relation: _____

_____ Leave Message on answering machine at HOME regarding my appointments or text my cell.

_____ Other: _____

I understand I have the right to revoke this permission in writing at any time, except to the extent that Memorial Physicians Clinics physicians have already taken action.

_____ _____

Patient Signature Date

_____

Name and relationship to patient (if signed by a personal representative of the patient)

_____ _____

Witness Date

Bowel Symptom Questionnaire

Name: _____Date: _____
Doctor: _____

Which symptoms best describe you? Select all that apply.

Accidental loss of leakage of stool – sometimes unable to make it to the bathroom in time
Bowel accidents while unaware – no warning and/or while asleep
Frequent loose, watery stools
Sudden or strong urge to go to the bathroom
Bowel accidents when passing gas
No bowel problems (if checked, please discontinue questionnaire)

How long have you had these symptoms?
Approximately how many bowel incidents do you have per week?
Have you tried medications to help your symptoms ? Yes No
On a scale of 1 to 10, with 0 being no symptom relief and 10 being complete symptom relief, how much symptom relief have these medications provided for you? Select Number .

1	2	3	4	5	6	7	8	9	10

No relief *Complete Relief*

Behavior modifications tried?

On a scale of 1-10, with 1 being no frustration at all and 10 being extremely frustrated, what is your level of frustration with your bowel control symptoms? Select a number.

1	2	3	4	5	6	7	8	9	10

Not frustrated *very frustrated*

Are you interested in learning more about additional treatment alternatives to bowel medications? Yes No