ADVANCED GI INC

PATIENT REGISTRATION FORMS

☐ New Patient Registration
☐ Updated Patient Registration

PATIENT INFORMATION (please print) Gender: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Name (First, MI, Last): ______________________ Date of Birth: __________ SS #: ____________

Mailing Address: ______________________ City: ______________ Zip: __________

Address: ______________________ City: ______________ Zip: __________

Primary Ph: (_____) ____________ Cell: (_____) ____________ Alt Phone: (____) ____________

E-mail: ______________________ Driver's Lic: ______________________

Referring Doctor: ______________________ Primary Care Doctor: ______________________

Phone: (____ __) ____________ Phone: (_____ __) ____________

How did you hear about us? ☐ MD ☐ Friend ☐ Family ☐ LRMC ☐ News Paper __________ ☐ On-Line: __________

May our staff leave messages on home phone? ☐ Yes ☐ No or, with family member? Who? ______________

Would you like to receive your test results by E-mail (Via Secure Patient Portal)? ☐ Yes ☐ No

May our staff call or leave messages with your listed work number? ☐ Yes ☐ No

May our staff utilize your E-mail/Secure Patient Portal for correspondence or as a means to reach you? ☐ Yes ☐ No

Do you consent for our staff to obtain your current Pharmacy records/prescriptions (Electronic Prescriptions)? ☐ Yes ☐ No

Current Pharmacy to send Prescriptions: ______________________ Phone: (_____) ____________

Address: ______________ City: ______________________ State: ______ Zip: __________

Patient Employment Information

☐ Employed ☐ Retired ☐ Unemployed ☐ Student

Employer Name: ______________________

Address: ______________________

City: ______________ Zip: __________

Occupation: ______________________

Emergency Contacts "NOT" Living with you:

	Name	Relationship	phone
1.			
2.			
3.			

Insurance Information (If you are Insured through someone else, please list that persons information below)

Ins. Company Name: ______________________ ID #: ______________________

Group/Policy #: ______________________ Group/Policy Name: ______________________

Subscriber's Name: ______________________ Subscriber's SSN: ______________________

Relationship to Patient: ______________________ Subscriber's Date of Birth: ______________________

Subscriber's Employer: ______________________ Phone: (______) ______________________

Secondary Insurance

Ins. Company Name: ______________________ ID #: ______________________

Group/Policy #: ______________________ Group/Policy Name: ______________________

Subscriber's Name: ______________________ Subscriber's SSN: ______________________

Relationship to Patient: ______________________ Subscriber's Date of Birth: ______________________

Subscriber's Employer: ______________________ Phone: (______) ______________________

INSURED PATIENT PAYMENT POLICY

Patient Responsibility: You are responsible for all charges resulting from treatment provided by AGI (Advanced Gastroenterology, Inc.), we bill most insurance carriers. However, primary responsibility for the account is yours. Your co-payment is due at the time of service; any remaining balance owed by you is due when statement is received, unless other financial arrangements are made. If you have a delinquent balance, you will be expected to pay on next visit. Surgery scheduled once all accounts are current and paid in full, or if other arrangements have been made ahead of time (such as payment schedule).

Minors: Patients under 18 years of age will be the responsibility of the custodial parent(s)/Guardian(s).
You are responsible for notifying AGI of any cancellations or changes to scheduled appointments or procedures. Fees: Office Appointments $25 without 24 hour advanced notice. Procedure appointments $200 fee for changes or cancellations within 5 days of scheduled procedure date. On-line Patient Portal messages and other means of communication requiring doctor's response may be charged between $25 – $100 each, (this service is not covered by your insurance).

Insurance Billings: It is your responsibility (or that of the financially responsible party) to provide current, accurate insurance billing information. If your insurance information changes you must provide the new insurance information to AGI prior to receiving additional care. If your insurance coverage is not in effect at the time you receive care, or if your plan does not cover the services that you receive, you will be responsible to pay the charges.

Medicare: We participate with Medicare. We will bill Medicare as your primary insurer; we will also bill your supplemental insurance provider. Medicaid: WE ARE NOT CONTRACTED WITH THIS CARRIER, You will be fully responsible for services provided to you.

Check Returned: It is our office policy to charge a $25 fee for checks that are returned due to *non-sufficient funds*.

Authorization to Release Information: In obtaining payment for services, I authorize my healthcare provider AGI to furnish information from my medical record to any company that may be responsible for payment for all or part of my provider charges, including but not limited to: my insurance companies and their representative, and my employer or union if they are involved in processing the claim. I have been provided with a copy of the *Notice of Privacy Information Practices. For further information regarding disclosure of health information, please refer to the Notice of Privacy Information Practices which has been provided to you and available in our office or on our website: www.agimedical.com*

If I have been referred by, or am referred to another healthcare provider, I authorize AGI to release my medical information to this provider for continuing care. I also assign AGI all payments to which I am entitled for medical expenses related to the services reported herewith. I understand I am financially responsible for all charges whether covered by my insurance provider or not. I also understand that balances outstanding for more than 90 days may be subject to a processing fee.

Please answer the following questions:

Question			Question		
Did you sustain an injury at work?	Yes	No	Are you covered under an employer /union policy?	Yes	No
Are your injuries accident related?	Yes	No	Is your spouse/other family member employed?	Yes	No
Are you currently employed?	Yes	No	Do you have a secondary insurance policy?	Yes	No
Have you ever served in the military?	Yes	No	Are you covered under any other health care plan?	Yes	No
I am a new patient to this practice	Yes	No	Have you made any changes to your choice of Medicare options in the last open enrollment period?	Yes	No
Who is responsible for this bill?	Name:			Relationship to Patient:	

I, or my appointed agent, have read, fully understand, and agree to the above statements. I can request a copy of this policy at any time. I attest that the information I have given here is correct and true to the best of my knowledge. I understand that I am responsible for keeping the doctor updated with the current information regarding my account.

____________________ X____________________ __________

Patient Name (Please print) Patient signature Date

If the patient is under the age of 18 years, or is otherwise unable to sign, complete the following:

Patient is __________ years of age or is unable to sign because: ____________________

____________________ X____________________ __________

Patient Name (Please Print) POA / Guardian / Guarantor's Signature Date

ADVANCED GI INC

Patient Health History

Last Name: ______________________ First Name: ______________________ MI: ______
Date of Birth: ______________________ Age: __________
Primary Medical doctor (PMD): ____
Referring doctor (if different from PMD): ______________________________________

Main reason for visit: ____
Race: □ White / Caucasian □ Black or African American □ Asian □ Hispanic / Latino □ American Indian / Alaska Native □ Native Hawaiian / Other Pacific Islander □ Mixed □ Other □ Unknown □ Patient declines to provide information
Ethnicity: □ Hispanic / Latino □ Not Hispanic / Latino □ Patient declines to provide information
Gender: □ Male □ Female
Preferred Language: □ English □ Spanish □ Other: ________________
Contact Preference: □ Letter □ Telephone call □ e-mail: ________________

Immunizations: □ None □ Flu When:________ □ Pneumonia When: ________
□ Hepatitis A When: ________ □ Hepatitis B When: ________

Previous Surgeries / Procedures: □ None
□ Colonoscopy Date: ______________findings: ______________________
□ EGD Date: ______________ findings: ______________________
□ Appendectomy □ Gallbladder □ Hernia Repair □ C-section □ Tubal ligation □ Hysterectomy
□ Ovaries □ Tonsillectomy □ Laparoscopy □ Gastric bypass □ Gastric banding (Lap Band) □ TIF
□ Nissen Fudoplication □ Coronary artery bypass □ Heart valve replacement □ Pacemaker □ Defibrillator
□ Other abdominal ______________ □ Other ____________

Past or Present Medical Conditions: □ None
Gastrointestinal: □Hepatitis A □Hepatitis B □Hepatitis C □Jaundice □ Cirrhosis □ Liver disease □ Peptic ulcer disease □ H. Pylori □ Lactose intolerance □ GERD / Heartburn □ Pancreatitis □ Gallstones □ Diverticulitis
Cardiovascular: □ High blood pressure □ High cholesterol □ High triglycerides □ History of heart attack/angina □ Congestive heart failure □ Atrial fibrillation □ Other heart rhythm disturbance
Respiratory/Lung: □ Chronic bronchitis □ Emphysema □ Asthma □ Sleep apnea □ Pulmonary embolism
Neurology: □ Migraine □ Stroke □ T.I.A . □ Seizure
Endocrine: □ Osteoporosis □ Osteopenia □ Diabetes □ Hypothyroid □ Hyperthyroidism
Genitourinary: □ Kidney stone □ Kidney failure □ Prostate enlargement
Eye: □ Glaucoma □ Cataracts □ Conjunctivitis
Rheumatology: □ Arthritis □ Lupus □Rheumatoid arthritis □ Sjogrens □ Scleroderma
Psychology: □ Anxiety □ Depression □ Panic attacks
Hematology: □ Anemia □ Blood disorder □ History of leg clots (DVT)
Oncology: □ Breast cancer □ Colon cancer □ Prostate cancer □ Ovarian cancer □ Pancreatic cancer □ Lung cancer

Pharmacy (we can send medications electronically to your preferred pharmacy):
Name: ______________________ City: ________________ Phone: ____________
Current Medications: □ None
Name / Dose / Frequency: ____________ | ____________ | ____________
Name / Dose / Frequency: ____________ | ____________ | ____________
Name / Dose / Frequency: ____________ | ____________ | ____________
Name / Dose / Frequency: ____________ | ____________ | ____________
Name / Dose / Frequency: ____________ | ____________ | ____________
Name / Dose / Frequency: ____________ | ____________ | ____________

Name: ______________________________ Date: ____________________

Last Name: ______________________________ First Name: ___________________________ MI: __________

Allergies:

□ Patient has no known drug allergies

□ Iodine □ Latex □ Penicillin □ Codeine □ Sulfa (sulfonamides) □ Other : ________________

Social History:

Occupation: ____

Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed

Tobacco/smoking status:

□ Current every day smoker □ Current someday smoker □ Former smoker

□ Never smoker □ Unknown if ever smoked

Alcohol: □ Social □ Daily □ Heavy □ Never

Quantity / Frequency: ____

Drug Use: □ None Type / Quantity / Frequency: ____

Caffeine: □ None Type / Quantity / Frequency: ____

Exercise: □ None Type / Quantity / Frequency: ____

Family Medical History:

□ No knowledge of family history / Adopted

□ No family history of Colon cancer □ IBD (Ulcerative Colitis or Crohn's)

F=Father M=Mother B=Brother S=Sister GF=Grandfather GM= Grandmother

Colon Cancer □ Relation: ________ Age: _____ Colon Polyp □ Relation: ________ Age: _____

Esophageal Cancer □ Relation: ________ Age: ____ Barrett's Esophagus: □ Relation: ________ Age: _____

Stomach Cancer □ Relation: ________ Age: _____ Pancreatic Cancer □ Relation: ________ Age: _____

Peptic Ulcer Disease □ Relation: ________ Age: _____ Gallbladder Disease □ Relation: ________ Age: _____

Gallstones □ Relation: ________ Age: _____ Pancreatitis □ Relation: ________ Age: _____

Ulcerative Colitis □ Relation: ________ Age: _____ Crohn's Disease (chronic) □ Relation: ________ Age: _____

Celiac Disease □ Relation: ________ Age: _____ Rheumatoid arthritis □ Relation: ________ Age: _____

Lupus □ Relation: ________ Age: _____ Cirrhosis □ Relation: ________ Age: _____

Liver Disease □ Relation: ________ Age: _____ Hemochromatosis □ Relation: ________ Age: _____

Ovarian Cancer □ Relation: ________ Age: _____ Uterine Cancer □ Relation: ________ Age: _____

Prostate Cancer □ Relation: ________ Age: _____ Bladder Cancer □ Relation: ________ Age: _____

Review of Symptoms:

Constitutional: □ Recent weight loss □ Excessive fatigue □ Fever □ Chills

Skin: □ Rash □ Itching □ Bruising

Head/Ears/Eyes/Throat: □ Headache □ Blurred vision □ Eye redness □ Ringing in ears/tinnitus

□ Nose bleeds □ Recurrent mouth ulcers □ Hoarseness/voice changes □ Sore throat □ Sinusitis

Respiratory: □ Coughing blood □ Chronic cough □ Difficulty breathing □ Wheezing

Cardiovascular: □ Cramps with exercise □ Chest pain/pressure □ Palpitations □ Swelling in feet/ankles *Gastrointestinal:* □ Abdominal pain □ Black stool □ Bloating □ Blood in stool □ Constipation □ Diarrhea

□ Difficulty swallowing □ Gas □ Fill up quickly at meals □ Heartburn □ Loss of control of bowel movements (incontinence) □ Nausea □ Painful swallowing □ vomiting

Genitourinary: □ Blood in urine □ Frequent urination □ Urinary incontinence □ Painful urination

□ Excessive urination at night

Musculoskeletal: □ Back pain □ Joint pain □ Joint stiffness □ Muscle cramps

Neurological: □ Numbness □ Trouble walking (use of a cane/walker) □ Weakness in extremities

Psychiatric: □ Depression □ Insomnia □ Nervousness □ Suicidal ideation

Endocrine: □ Excessive thirst □Heat intolerance □ Thyroid problems

Hematologic/lymphatic: □ Anemia □ Enlarged lymph node □ Easy bruising