FLINT GASTROENTEROLOGY ASSOCIATES, PC

PATIENT REGISTRATION FORM

APPOINTMENT DATE:	TIME:	PROVIDER:

PATIENT INFORMATION

Legal name as printed on driver's license (please print) What name do you prefer to go by:		
LAST:	FIRST:	MIDDLE:

ADDRESS:	Phone: May we leave confidential messages? Y N		
	Home		
	Cell:		
	Work:		

BIRTH DATE:	Social Security Number:	Marital Status (circle one): Single Married Divorced Separated Widowed
GENDER AT BIRTH: M F		Email:
RACE: African American Asian Caucasian Hispanic Unknown Type out:		Language: English Other:

Occupation:	
Primary Care Physician Name:	Referring Doctor (if other than primary):
Office Phone #:	Office Phone #:
Office Fax #:	Office Fax #:
Pharmacy:	Name of Emergency Contact:
Phone #:	Phone #:
Location:	Relationship to patient:

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name:	Relation:	Phone#: ( )
Name:	Relation:	Phone#: ( )

INSURANCE INFORMATION

PLEASE PRESENT INSURANCE CARDS* THEY WILL NEED TO BE SCANNED**

PRIMARY INSURANCE:	SECONDARY INSURANCE:
GROUP#:	GROUP #:
CONTRACT#	CONTRACT #:
SUBSCRIBER:	SUNSCRIBER:
BIRTHDATE:	BIRTHDATE:

***If required please put in the Referral/Insurance Auth:**

RELEASE OF INFORMATION

PRIVACY STATEMENT: We protect our patient's information and the records that we have about their health and the services received in our office. We must have your written, signed consent in order to disclose your health information for the purposes of your treatment, the payment of bills, appointment reminder, etc. I have received a copy of the Privacy Notice (HIPPA-164.520). If we refer our patients to another provider or specialist, we may need to share your information with them. Your privacy is protected as only minimum information is shared.

FINANCIAL RESPONSIBILITY: I authorize the release of medical information to insurance carriers concerning my illness and treatment and I hereby Assign to the doctor all payments for medical services rendered to me or my dependent. I understand that I am responsible for any amount not covered by insurance and that I will pay any copay on the date of services rendered unless other arrangements are made.

Patient/Guardian Signature:	Date:

MEDICARE AUTHORIZATION: I request that payment of authorized Medicare benefits be made to Flint Gastroenterology Associates, PC on my behalf. I authorize the holder of my medical information to release to the HCFA and their agents any information needed to determine these benefits for related services. I understand that HFCA is the government Medicare Agency.

Medicare Beneficiary Signature:	Date:

PT REVIEWED: ________________________ Date_______________________

FLINT GASTROENTEROLOGY ASSOCIATES, PC

Patient Questionnaire

Last:	First:	Middle:

Review of Systems - Please check any current problems/symptoms that apply

Constitutional

- ☐ Fever
- ☐ Weight Loss
- ☐ Chills
- ☐ Weight Gain
- ☐ Night Sweats
- ☐ Feeling Tired/Sluggish
- ☐ Generalized Weakness
- ☐ Trouble Sleeping
- ☐ Other:

Eyes

- ☐ Eye Pain
- ☐ Dryness
- ☐ Blurred Vision
- ☐ Eyesight Problems
- ☐ Double Vision
- ☐ Corrective Lenses
- ☐ Glaucoma
- ☐ Eye Redness
- ☐ Other:

Ear/Nose/Throat/Mouth

- ☐ Earache
- ☐ Trouble Swallowing
- ☐ Hearing Loss
- ☐ Mouth Sores
- ☐ Ringing in Ears
- ☐ Hoarseness
- ☐ Nasal Discharge
- ☐ Sore Throat
- ☐ Nosebleeds
- ☐ Sinus Pain
- ☐ Other:

Cardiovascular

- ☐ Slow Heart Rate
- ☐ Lightheadedness
- ☐ Fast Heart Rate
- ☐ Palpitations
- ☐ Chest Pain
- ☐ Angina
- ☐ High Blood Pressure
- ☐ Swelling of Legs
- ☐ Other:

Respiratory

- ☐ Shortness of Breath (at rest)
- ☐ Cough
- ☐ Shortness of Breath (on exertion)
- ☐ Cough with Mucus
- ☐ Wheezing
- ☐ Cough with Blood
- ☐ Chest Tightness
- ☐ Sleep Apnea: Uses CPAP - or- Does not use CPAP
- ☐ Other:

Gastrointestinal

- ☐ Abdominal Distention
- ☐ Diarrhea
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Abdominal Cramping
- ☐ Bloating
- ☐ Nausea
- ☐ Rectal Pain
- ☐ Vomiting
- ☐ Blood in Stool
- ☐ Indigestion/Heartburn
- ☐ Fecal Leakage
- ☐ Other:

Musculoskeletal

- ☐ Back Pain
- ☐ Neck Pain
- ☐ Joint Pain
- ☐ Muscle Weakness
- ☐ Limb Pain
- ☐ Joint Stiffness
- ☐ Muscle Pain
- ☐ Joint Swelling
- ☐ Other:

Skin

- ☐ Skin Rash
- ☐ Dry Skin
- ☐ Skin Lesion
- ☐ Eczema
- ☐ Skin Wound
- ☐ Change in Color of Skin
- ☐ Itching
- ☐ Change in Hair
- ☐ Other:

Neurological

- ☐ Headaches
- ☐ Loss of Memory
- ☐ Confusion
- ☐ Poor Balance
- ☐ Speech Problems
- ☐ Difficulty Walking
- ☐ Numbness
- ☐ Weakness
- ☐ Tingling
- ☐ Dizziness
- ☐ Changes in Senses
- ☐ Seizures
- ☐ Other:

Psychiatric

- ☐ Depression
- ☐ Anxiety
- ☐ Sleep Pattern Changes
- ☐ Paranoia
- ☐ Difficulty Concentrating
- ☐ Change in Personality
- ☐ Episodes of Mania
- ☐ Suicidal Thoughts
- ☐ Agitation
- ☐ Other:

Endocrine

- ☐ Pre Diabetic
- ☐ Heat Intolerance
- ☐ Diabetes
- ☐ Cold Intolerance
- ☐ Hypoglycemia
- ☐ Excessive Thirst
- ☐ Hypothyroid
- ☐ Sweating
- ☐ Hyperthyroid
- ☐ Hot Flashes
- ☐ Other:

Hematologic/Lymphatic

- ☐ Anemia
- ☐ Swollen Lymph Nodes
- ☐ Bruises Easily
- ☐ Night Sweats
- ☐ Bleeds Easily
- ☐ Pale
- ☐ Clotting Disorder
- ☐ Other:

Genitourinary

- ☐ Nocturia (going at night)
- ☐ Blood in Urine
- ☐ Dysuria (painful urination)
- ☐ Urine Frequency
- ☐ Difficulty Urinating
- ☐ Incontinence
- ☐ Other:

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Patient Questionnaire

Last:	First:	Middle:

Gastrointestinal History

What is your chief problem/concern? ______________________

How long have you had this problem? ______________________

Have you ever had a colonoscopy? Y N When? ________ Performing Doctor: ________

Have you ever had an EGD/upper scope? Y N When? ________ Performing Doctor: ________

Have you had any recent radiology exams (ultrasound, CT, MRI, or x ray)? ______________________

Have you had any recent lab work completed? ______________________

Medical History - Please check any of the medical conditions for which you have seen a doctor.

- ☐ None
- ☐ Anemia
- ☐ Anxiety Disorder
- **Arthritis**
  - ☐ Osteoarthritis
  - ☐ Rheumatoid
- ☐ Asthma
- **Cancer**
  - ☐ Breast
  - ☐ Colon
  - ☐ Esophageal
  - ☐ Kidney
  - ☐ Liver
  - ☐ Lung
  - ☐ Ovarian
  - ☐ Prostate
  - ☐ Stomach
  - ☐ Uterine
- ☐ Celiac Disease
- ☐ Colon Polyps
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Crohn's Disease
- ☐ Dementia/Alzheimer's
- ☐ Depression
- ☐ Diabetes
- **Diverticular Disease**
  - ☐ Diverticulitis
  - ☐ Diverticulosis
- ☐ Emphysema
- **Esophageal Disease**
  - ☐ Barrett's Esophagus
  - ☐ Varices
- ☐ Fibromyalgia
- ☐ Gallstones
- ☐ Glaucoma
- ☐ Heart Attack
- ☐ Heart Valve Disease
- **Heart Arrhythmias**
  - ☐ Atrial Fibrillation
  - ☐ Tachycardia
  - ☐ Bradycardia
  - ☐ SVT
- ☐ Hemorrhoids
- **Hepatitis/Liver Disease**
  - ☐ Cirrhosis
  - ☐ Hepatitis A
  - ☐ Hepatitis B
  - ☐ Hepatitis C
  - ☐ Jaundice
- ☐ Hiatal Hernia
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Migraine
- ☐ Pancreatitis
- ☐ Parkinson's Disease
- ☐ Reflux (GERD)
- ☐ Sarcoidosis
- ☐ Seizure Disorder
- ☐ Sjogren's Disease
- ☐ Sleep Apnea/CPAP
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Ulcerative Colitis
- ☐ Other ________

Surgical History - Please check any of the surgeries that you have had.

- ☐ None
- ☐ Appendix Removal
- ☐ Back Surgery
- ☐ Carpal Tunnel Release
- **Colon Surgery**
  - ☐ Colectomy
  - ☐ Partial Colectomy
  - ☐ Colostomy
  - ☐ Ileostomy
- ☐ C-Section
- **Feeding tube**
  - ☐ G tube
  - ☐ J tube
- ☐ Gastric Sleeve
- ☐ Roux en Y
- ☐ Gallbladder Surgery
- ☐ Heart Stents
- ☐ AICD Placement
- ☐ Heart Surgery/Bypass
- ☐ Heart Valve Replacement
- ☐ Hernia Repair
- ☐ Hiatal Hernia Surgery
- ☐ Hysterectomy
- **Joint Replacement/Joint Surgery**
  - ☐ Hip Replacement
  - ☐ Knee Replacement
  - ☐ Shoulder Replacement
  - ☐ Joint Surgery________
- ☐ Laparoscopy (abdominal)
- ☐ Liver Biopsy
- ☐ Lung Surgery
- ☐ Mastectomy Surgery
- ☐ Prostate
- ☐ Small Bowel Resection
- **Throat/Mouth Surgery**
  - ☐ Tonsillectomy
  - ☐ Adenoidectomy
  - ☐ Wisdom Teeth
  - ☐ Other ________
- ☐ Thyroidectomy
- ☐ Transplant
- ☐ Tubal Ligation
- ☐ Other ________

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Patient Questionnaire

Last:	First:	Middle:

Family Medical History

	Father	Mother	Children	Brother	Sister	Other Relatives
Colon or Rectal Cancer	☐ At age ___	☐ At age ___	☐ At age ___	☐ At age ___	☐ At age ___	☐ ________________
Colon Polyps	☐ At age ___	☐ At age ___	☐ At age ___	☐ At age ___	☐ At age ___	☐ ________________
Crohn's Disease	☐	☐	☐	☐	☐	☐ ________________
Esophageal Cancer	☐	☐	☐	☐	☐	☐ ________________
Kidney Cancer	☐	☐	☐	☐	☐	☐ ________________
Liver Cancer	☐	☐	☐	☐	☐	☐ ________________
Liver Disease	☐	☐	☐	☐	☐	☐ ________________
Ovarian Cancer	N/A	☐	☐	N/A	☐	☐ ________________
Pancreatitis	☐	☐	☐	☐	☐	☐ ________________
Stomach Cancer	☐	☐	☐	☐	☐	☐ ________________
Ulcerative Colitis	☐	☐	☐	☐	☐	☐ ________________
Uterine Cancer	N/A	☐	☐	N/A	☐	☐ ________________
Other Cancer (please specify):						

Social History

Do you use tobacco? ☐ Yes ☐ No
Type ________________________________
# of years______ packs per day______
Quit (*year*) _______ age started _______ age stopped _______

Do you vape? ☐ Yes ☐ No
# of years _________

Do you currently use recreational drugs? ☐ Yes ☐ No
Type ________________________________
Frequency ____________________________

Do you consume alcoholic drinks? ☐ Yes ☐ No
Type ________________________________
Frequency/Amount ______________________________
Do you have a history of alcoholism? ☐ Yes ☐ No
Years of sobriety _________________________

Do you drink/consume caffeine? ☐ Yes ☐ No
Type ________________________________
Amount per day ______________________________

Do you follow any special diets? ☐ Yes ☐ No
Type ________________________________

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Patient Questionnaire

Last:	First:	Middle:

Allergies/Reactions

Please list any allergies or reactions to medications, foods, latex, or dyes, as well as the type of reaction you experienced (example: difficulty breathing, hives, etc.):

Medications/Dosages

Please list all medications and doses. Include vitamins, herbal supplements and over-the-counter medications:

Medication	Dosage	How Often Taken