FLINT GASTROENTEROLOGY ASSOCIATES, PC

PATIENT REGISTRATION FORM

Appointment Date:	Time:	Doctor:

PATIENT INFORMATION

Legal name as printed on driver's license (please print)

Last:	First:	Middle:

Address:	Phone: May we leave confidential messages? Y N
	Home: ( )
	Cell: ( )
	Work: ( )
Birth Date: / / Sex: M F	Marital Status (circle one): Single Married Divorced Separated Widowed
Social Security Number: - -	Email:
Race: ☐African American ☐Asian ☐Caucasian ☐Hispanic ☐Unknown Other: _____	Language: ☐English Other: _____
Occupation:	Employer:
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*****

Primary Insurance:	Secondary Insurance:
Relation to Subscriber:	Relation to Subscriber:

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.

Patient/Guardian Signature:	Date:

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:

FLINT GASTROENTEROLOGY ASSOCIATES, PC

Patient Questionnaire

Last:	First:	Middle:

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

Constitutional

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

Musculoskeletal

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

Eyes

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

Skin

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

Ear/Nose/Throat/Mouth

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

Neurological

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

Cardiovascular

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

Psychiatric

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

Respiratory

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

Endocrine

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

Gastrointestinal

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

Hematologic/Lymphatic

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

Genitourinary

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