

**FLINT GASTROENTEROLOGY ASSOCIATES, PC**

**PATIENT REGISTRATION FORM**

<b>APPOINTMENT DATE:</b>			<b>TIME:</b>			<b>DOCTOR:</b>		
<b>PATIENT INFORMATION</b>								
Legal name as printed on driver's license (please print)    What name do you prefer to go by:								
<b>LAST:</b>			<b>FIRST:</b>			<b>MIDDLE:</b>		
<b>ADDRESS:</b>						<b>Phone:</b> May we leave confidential messages?    Y    N		
						Home: (    )		
						Cell: (    )		
						Work: (    )		
<b>BIRTH DATE:</b> /    /			<b>Social Security Number:</b>			<b>Marital Status (circle one):</b> Single    Married    Divorced    Separated    Widowed		
<b>GENDER AT BIRTH:</b> M    F						<b>Email:</b>		
<b>RACE:</b> African American    Asian    Caucasian    Hispanic    Unknown Other: <input type="checkbox"/>						Language:    English    Other: <input type="checkbox"/>		
Occupation:								
<b>Primary Care Physician Name:</b>						<b>Referring Doctor (if other than primary):</b>		
Office Phone #: (    )						Office Phone #: (    )		
Office Fax #: (    )						Office Fax #: (    )		
<b>Pharmacy:</b>						<b>Name of Emergency Contact:</b>		
Phone #: (    )						Phone #: (    )		
Location:						Relationship to patient:		
<b>AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION</b>								
Name:			Relation:			Phone#: (    )		
Name:			Relation:			Phone#: (    )		
<b>INSURANCE INFORMATION</b>								
<b>PLEASE PRESENT INSURANCE CARDS*** THEY WILL NEED TO BE SCANNED</b>								
<b>PRIMARY INSURANCE:</b>					<b>SECONDARY INSURANCE:</b>			
<b>GROUP#:</b>					<b>GROUP #:</b>			
<b>CONTRACT#</b>					<b>CONTRACT #:</b>			
<b>SUBSCRIBER:</b>					<b>SUNSCRIBER:</b>			
<b>BIRTHDATE:</b>					<b>BIRTHDATE:</b>			
<b>*If required please put in the Referral/Insurance Auth:</b>								
<b>RELEASE OF INFORMATION</b>								
<p><b>PRIVACY STATEMENT:</b> 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.</p> <p><b>FINANCIAL RESPONSIBILITY:</b> 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.</p>								
<b>Patient/Guardian Signature:</b>							<b>Date:</b>	
<p><b>MEDICARE AUTHORIZATION:</b> 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.</p>								
<b>Medicare Beneficiary Signature:</b>							<b>Date:</b>	

PT REVIEWED: \_\_\_\_\_ Date \_\_\_\_\_

updated 04/23/2023

**FLINT GASTROENTEROLOGY ASSOCIATES, PC**

**Patient Questionnaire**

Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

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

Constitutional	Musculoskeletal
<input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Night Sweats <input type="checkbox"/> Generalized Weakness <input type="checkbox"/> Other:	<input type="checkbox"/> Back Pain <input type="checkbox"/> Joint Pain <input type="checkbox"/> Limb Pain <input type="checkbox"/> Muscle Pain <input type="checkbox"/> Other:
<input type="checkbox"/> Weight Loss <input type="checkbox"/> Weight Gain <input type="checkbox"/> Feeling Tired/Sluggish <input type="checkbox"/> Trouble Sleeping	<input type="checkbox"/> Neck Pain <input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Joint Stiffness <input type="checkbox"/> Joint Swelling
Eyes	Skin
<input type="checkbox"/> Eye Pain <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Double Vision <input type="checkbox"/> Glaucoma <input type="checkbox"/> Other:	<input type="checkbox"/> Skin Rash <input type="checkbox"/> Skin Lesion <input type="checkbox"/> Skin Wound <input type="checkbox"/> Itching <input type="checkbox"/> Other:
<input type="checkbox"/> Dryness <input type="checkbox"/> Eyesight Problems <input type="checkbox"/> Corrective Lenses <input type="checkbox"/> Eye Redness	<input type="checkbox"/> Dry Skin <input type="checkbox"/> Eczema <input type="checkbox"/> Change in Color of Skin <input type="checkbox"/> Change in Hair
Ear/Nose/Throat/Mouth	Neurological
<input type="checkbox"/> Earache <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Nasal Discharge <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Other:	<input type="checkbox"/> Headaches <input type="checkbox"/> Confusion <input type="checkbox"/> Speech Problems <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Changes in Senses <input type="checkbox"/> Other:
<input type="checkbox"/> Trouble Swallowing <input type="checkbox"/> Mouth Sores <input type="checkbox"/> Hoarseness <input type="checkbox"/> Sore Throat <input type="checkbox"/> Sinus Pain	<input type="checkbox"/> Loss of Memory <input type="checkbox"/> Poor Balance <input type="checkbox"/> Difficulty Walking <input type="checkbox"/> Weakness <input type="checkbox"/> Dizziness <input type="checkbox"/> Seizures
Cardiovascular	Psychiatric
<input type="checkbox"/> Slow Heart Rate <input type="checkbox"/> Fast Heart Rate <input type="checkbox"/> Chest Pain <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Other:	<input type="checkbox"/> Depression <input type="checkbox"/> Sleep Pattern Changes <input type="checkbox"/> Difficulty Concentrating <input type="checkbox"/> Episodes of Mania <input type="checkbox"/> Agitation <input type="checkbox"/> Other:
<input type="checkbox"/> Lightheadedness <input type="checkbox"/> Palpitations <input type="checkbox"/> Angina <input type="checkbox"/> Swelling of Legs	<input type="checkbox"/> Anxiety <input type="checkbox"/> Paranoia <input type="checkbox"/> Change in Personality <input type="checkbox"/> Suicidal Thoughts
Respiratory	Endocrine
<input type="checkbox"/> Shortness of Breath (at rest) <input type="checkbox"/> Shortness of Breath (on exertion) <input type="checkbox"/> Wheezing <input type="checkbox"/> Chest Tightness <input type="checkbox"/> Sleep Apnea: Uses CPAP - or- Does not use CPAP <input type="checkbox"/> Other:	<input type="checkbox"/> Pre Diabetic <input type="checkbox"/> Diabetes <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Hypothyroid <input type="checkbox"/> Hyperthyroid <input type="checkbox"/> Other:
<input type="checkbox"/> Cough <input type="checkbox"/> Cough with Mucus <input type="checkbox"/> Cough with Blood	<input type="checkbox"/> Heat Intolerance <input type="checkbox"/> Cold Intolerance <input type="checkbox"/> Excessive Thirst <input type="checkbox"/> Sweating <input type="checkbox"/> Hot Flashes
Gastrointestinal	Hematologic/Lymphatic
<input type="checkbox"/> Abdominal Distention <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Abdominal Cramping <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Indigestion/Heartburn <input type="checkbox"/> Other:	<input type="checkbox"/> Anemia <input type="checkbox"/> Bruises Easily <input type="checkbox"/> Bleeds Easily <input type="checkbox"/> Clotting Disorder <input type="checkbox"/> Other:
<input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bloating <input type="checkbox"/> Rectal Pain <input type="checkbox"/> Blood in Stool <input type="checkbox"/> Fecal Leakage	<input type="checkbox"/> Swollen Lymph Nodes <input type="checkbox"/> Night Sweats <input type="checkbox"/> Pale
	Genitourinary
	<input type="checkbox"/> Nocturia (going at night) <input type="checkbox"/> Dysuria (painful urination) <input type="checkbox"/> Difficulty Urinating <input type="checkbox"/> Other:
	<input type="checkbox"/> Blood in Urine <input type="checkbox"/> Urine Frequency <input type="checkbox"/> Incontinence

**FLINT GASTROENTEROLOGY ASSOCIATES, PC**

**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.**

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

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

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

**FLINT GASTROENTEROLOGY ASSOCIATES, PC**

**Patient Questionnaire**

Last:	First:	Middle:
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**Family Medical History**

	Father	Mother	Children	Brother	Sister	Other Relatives
Colon or Rectal Cancer	<input type="checkbox"/> At age ____	<input type="checkbox"/> At age ____	<input type="checkbox"/> At age ____	<input type="checkbox"/> At age ____	<input type="checkbox"/> At age ____	<input type="checkbox"/> _____
Colon Polyps	<input type="checkbox"/> At age ____	<input type="checkbox"/> At age ____	<input type="checkbox"/> At age ____	<input type="checkbox"/> At age ____	<input type="checkbox"/> At age ____	<input type="checkbox"/> _____
Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Esophageal Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Kidney Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Liver Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Ovarian Cancer	N/A	<input type="checkbox"/>	<input type="checkbox"/>	N/A	<input type="checkbox"/>	<input type="checkbox"/> _____
Pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Stomach Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Uterine Cancer	N/A	<input type="checkbox"/>	<input type="checkbox"/>	N/A	<input type="checkbox"/>	<input type="checkbox"/> _____
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 \_\_\_\_\_

FLINT GASTROENTEROLOGY ASSOCIATES, PC

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.):

Three horizontal lines for writing allergies and reactions.

Medications/Dosages

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

Table with 3 columns: Medication, Dosage, How Often Taken. Contains 20 rows of horizontal lines for data entry.