WESTCHASE GASTROENTEROLOGY

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New Patient Registration

(*Please print clearly and fill out the questionnaire completely*)

Today's Date: _____

Patient Name (Last, First, M.I.): _____

Date of Birth: _____ /_____ /_____ Age: _____ Gender: ☐ Male ☐ Female

Social Security #: _____-_____-_____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow/er

Address (Street):_____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Mobile: (_____) _____Work: (_____) _____

Which is the best number to reach you? _____ Email: _____

Occupation: _____ Employer: _____

Primary Care Physician: _____ Phone: (_____) _____

Pharmacy Name: _____ Telephone:_____

Emergency Contact(s)

Name & Relationship: _____ Phone: (_____) _____

Name & Relationship: _____ Phone: (_____) _____

Insurance Information and Responsible Party

Primary Insurance Company: _____ ID: _____

Secondary Insurance Company: _____ ID: _____

Policy Holder Name: _____ DOB: _____/_____/_____

Relationship to Patient: _____ Responsible Party: _____

_____ _____
Patient Signature Date

Patient Health Questionnaire: Health History

Please indicate the symptoms you currently have/had in the past year:

General
- □ Anxiety
- □ Chills
- □ Difficulty sleeping
- □ Dizziness
- □ Fainting
- □ Fever
- □ Forgetfulness
- □ Headache
- □ Weight loss

Cardiovascular
- □ Chest pain
- □ Edema
- □ Heart murmur
- □ High blood pressure
- □ Low blood pressure
- □ Poor blood circulation

Gastrointestinal
- □ Abdominal pain
- □ Bloating, gas, flatulence
- □ Bowel changes
- □ Blood in stool
- □ Constipation
- □ Diarrhea
- □ Difficulty swallowing
- □ GI bleeding
- □ Heartburn
- □ Hemorrhoids
- □ Indigestion
- □ Nausea and vomiting
- □ Poor appetite
- □ Rectal bleeding
- □ Vomiting blood
- □ Weight loss

Genito-urinary
- □ Blood in urine
- □ Frequent urination
- □ Lack of bladder control
- □ Painful urination

Eyes, Ears, Nose, Throat
- □ Blurred vision
- □ Double vision
- □ Persistent cough
- □ Hoarseness in throat
- □ Earache
- □ Ringing in ears
- □ Ear discharge
- □ Loss of hearing
- □ Nosebleeds

Musculoskeletal
- □ Muscle weakness
- □ Numbness/tingling in hands
- □ Numbness/tingling in feet
- □ Pain in joints
- □ Muscle cramps
- □ Back/neck pain

Skin
- □ Bruising
- □ Hives
- □ Itching
- □ Rash
- □ Sores

Others, please specify:

Please indicate any history of the following medical conditions:

- □ Alcoholism
- □ Anemia
- □ Anorexia
- □ Asthma
- □ Autoimmune Disorders
- □ Blood disorder
- □ Bronchitis
- □ Bulimia
- □ Cancer
- □ Celiac Disease
- □ Colitis
- □ Crohn's Disease
- □ Cystic Fibrosis
- □ Depression
- □ Diabetes
- □ Diverticular Disease
- □ Emphysema/COPD
- □ Epilepsy
- □ Gallbladder Disease
- □ GERD
- □ Heart disease
- □ Hepatic Encephalopathy
- □ Hepatitis (type_____)
- □ Hiatal Hernia
- □ High cholesterol
- □ HIV/AIDS
- □ Irritable Bowel Syndrome
- □ Kidney disease
- □ Liver disease (Cirrhosis)
- □ Lupus
- □ Mental illness
- □ Migraine headaches
- □ Multiple Sclerosis
- □ Pancreatitis
- □ Peptic Ulcers Disease
- □ Polio
- □ Prostate complications
- □ Rheumatoid Arthritis
- □ Sleep apnea
- □ Stroke
- □ Thyroid Disease
- □ Ulcerative Colitis
- □ **Others, please specify:**

Please tell us your family's health history:

Relation	Age	Current state of health (well, ill, deceased)	Cause of death?
Father			
Mother			
Brother/Sister			
Brother/Sister			
Brother/Sister			

Please tell us of any previous hospitalizations:

Year	Reason/Outcome

Please tell us of any previous surgical histories:

Year	Reason/Outcome

Please list any medication(s), including OTC(s) and supplements you are taking:

Please list any drug allergies/intolerance: _____

_____

Do you have a history of pregnancy? ☐ Yes ☐ No
If yes, please indicate the year(s)/form of delivery: _____

_____

Do you currently/previously use tobacco? ☐ Yes ☐ No If yes, how many per day? _____

If previously used, how long? _____ Year stopped: _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how often? ☐ Daily: how many drinks daily? _____
☐ Sometimes ☐ Seldom

Please indicate any occupational risks:

☐ Stress ☐ Heavy lifting ☐ Exposure to hazardous substance ☐ Others, please specify:

_____

_____

I understand that it is my responsibility to inform the physician if I have any changes in my health. By signing below, I agree that I have completed this new patient registration to the best of my knowledge and as accurately as possible.

_____ _____
Patient Signature Date

Patient Health Questionnaire: Depression Screening

Name: _____ Date: _____

Over the **last two weeks**, how often have you been bothered by any of the following problems?

Check (✔) or circle the appropriate box	**Not at all**	**Several Days**	**More than half the days**	**Nearly everyday**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other to a noticeable extent, or, being so fidgety and restless as to move around more than usual	0	1	2	3
9. Thoughts that you'd be better off dead, or of hurting yourself	0	1	2	3

10. If you checked off *any* problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? **Circle your answer below.**

Not difficult at all Somewhat difficult Very difficult Extremely difficult

_____ _____

Patient Signature Date

Authorization of Examination, Treatment, and Use/Disclosure of Protected Healthcare Information (PHI) for Treatment, Payment, and Healthcare Operations Acknowledgement

I hereby authorize the physicians at Westchase Gastroenterology and staff to examine and/or render treatment. I understand that this may also include diagnostic imaging, use of scopes to examine internal organs, and lab tests (i.e. blood-work, pathology, etc.). I understand that I will receive explanation of ordered procedures/associated risks, and explanation of proper preparation for such procedures. I understand that I reserve the right to inquire about alternative courses of treatment and I will be given opportunity to have all of my questions answered.

I agree and understand that I have been provided with a Notice of Privacy Practices that provides a description on how my PHI will be used and disclosed. I understand that Westchase Gastroenterology reserves the right to change any policies at any time. I understand that I have the right to object to the use of my PHI for directory purposes. I understand that I reserve the right to request restrictions as to how my PHI is disclosed to carry out treatment, payment, and healthcare operations and that the practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the practice has already taken action in reliance thereon.

With whom may we share your PHI (full name/relationship to patient):

_____

_____

_____

By signing below, I acknowledge that I have received the Notice of Privacy Practices for the uses/disclosures of my protected health information, the General Administrative and Financial agreement, and Authorization of Examination. I understand these documents in full and I have been given the opportunity to have all of my questions answered.

_____
Print name

_____ _____
Patient Signature Date

General Administrative and Financial Agreement

The administrative and financial policies at Westchase Gastroenterology are discussed below. We reserve the right to make any amendments to these policies. Please feel free to ask any questions regarding these policies.

I agree and understand the following administrative and financial policies:

- It is entirely my responsibility to inform Westchase Gastroenterology of any changes in my demographic information (phone numbers, addresses, etc.)
- All self-pay, co-payments, co-insurance, and deductibles will be collected at the time of service via cash, credit and/or debit card.
- All payments must be collected upon arrival to the office, prior to service. It is your responsibility to ensure you have sufficient funds and acceptable form of currency to pay the required amount at the time of visit, or you may be rescheduled.
- If you are unable to keep your appointment, please provide us **at least a 24 business hour noticed. If you fail to cancel a scheduled appointment or provide less than a 24 business hour notification, you will be subject to a non-cancellation fee of $25.00.**
- There will be a fee up to $75.00 to complete any paperwork pertaining to FMLA, disability, etc. Fee is due upon delivery of paperwork. Forms will be completed within 7-10 business days from time of payment.
- If you need a refill on your medication(s) please have your pharmacy fax over a request. Your request will be addressed in 1 to 3 business days.
- We will deny your refill request if you have not had a follow up appointment in 6 months or more; you will need to make one and your physician will refill your medication(s) at the time of your appointment. Exception, unless you are instructed to return in one year and have made the next year appointment, then we will refill your medication until your next appointment date.

If you have health insurance coverage, we will submit your claims, however **we must emphasize that as medical providers, our relationship is with you, <u>not</u> your insurance company**. Please be advised that although we attempt to verify benefits with your insurance company, that this is only an estimate of your coverage based on the information provided to us at the time of the inquiry.

If I am covered by health insurance, I agree and understand the following policies:

- It is my responsibility to notify Westchase Gastroenterology of any changes to my insurance policy/information.
- I understand that if I have an insurance policy that requires a referral/authorization from my primary care physician or referring physician, **it is my responsibility to have the referral/authorization faxed to Westchase Gastroenterology prior to my appointment to avoid cancellation.**
- I understand that all services/procedures provided to me by Westchase Gastroenterology may not be covered 100% by my insurance plan. **I understand that I am financially responsible for any amounts/services not covered by my insurance plan.**
- I understand that a refund will be issued within 3 weeks from the date requested, provided that there are no pending insurance claims.

_____ _____

Patient Signature Date