

NORTHSIDE GASTROENTEROLOGY – CONFIDENTIAL-PATIENT REGISTRATION

Please Print

NAME: _____ DOB: _____
 ADDRESS: _____ CITY _____ STATE _____ ZIP _____
 HOME PHONE: (____) _____ Marital Status M S W D Social Security Number _____
 EMPLOYER: _____ WORK PHONE (____) _____
 PRIMARY INSURANCE: _____ ID NO. _____
 SECONDARY INSURANCE: _____ ID NO. _____
 NEXT OF KIN & RELATIONSHIP: _____

REVIEW OF SYSTEMS: Please CIRCLE yes or no if you have any of the following symptoms. If there are any questions you prefer not to answer below, leave unanswered and discuss them directly with the physician.

<u>GENERAL</u>	<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>	<u>For Physician Use</u>
Fevers	Y	N	Feeling too HOT/COLD	Y	N	_____
Weight Loss	Y	N	Night Sweats	Y	N	_____
<u>NOSE/MOUTH</u>						
Loss of smell	Y	N	Chronic sinus congestion	Y	N	_____
Frequent nose bleeds	Y	N	Loss of taste	Y	N	_____
Prolonged hoarseness	Y	N	Sores in the mouth	Y	N	_____
<u>LUNGS</u>						
Cough	Y	N	Short of breath lying down	Y	N	_____
Cough with sputum	Y	N	Short of breath at rest/exercise	Y	N	_____
Sputum with blood	Y	N	Chest pain with breathing	Y	N	_____
<u>HEART</u>						
High blood pressure	Y	N	Chest pain with activity	Y	N	_____
Heart Murmur	Y	N	Heart skips beats/beats too fast	Y	N	_____
Ever had a heart attack	Y	N	Bad heart valve	Y	N	_____
Passing out spells	Y	N	History of rheumatic fever	Y	N	_____

Referring Doctor _____ Reason for Referral _____

PLEASE CHECK IF ANY OF THESE PERTAIN TO YOU - Abdominal Pain ___ Change in Bowel Habits ___ Diarrhea ___

Constipation ___ Blood in Stool ___ Rectal Bleeding ___ Pain in Rectum ___ Black Tarry Stools ___ Chest Pain ___ Vomiting ___

Vomiting Blood ___ Difficulty Swallowing ___ Pain with swallowing ___ Food Gets Stuck in Esophagus ___ Hepatitis ___ Abnormal

Liver Blood Tests ___ Abnormal GI Tract X-ray or Study ___ If yes, what kind _____

Do You Smoke? _____ If yes, how much per day and for how long? _____

Do you drink alcoholic beverages? _____ If yes, how much per week _____

Do you drink coffee/caffeinated drinks? _____ If yes, how much per day _____

Do you take aspirin or aspirin-containing medicines? _____ If yes, please list _____

Have you had abdominal surgery? _____ If yes what type and when _____

List any allergies to medication _____

List all medications currently being taken with strength of medicine and how often you take it. _____

List any recent x-rays (NOT DENTAL) or scans and where they were done. _____

Do you have other medical problems? _____

CONFIDENTIAL MEDICAL INFORMATION

List Past Hospitalizations with most recent first.

<u>DATE</u>	<u>Hospital</u>	<u>Reason for Hospitalization</u>

List Medical Problems of Family Members. If deceased, state cause of death.

Father _____ Mother _____
Sister(s) _____ Brother(s) _____
Grandparents _____

Please explain anything else you think we should know, medical or non-medical _____

***** PLEASE READ BEFORE SIGNING *****

I request that payment of authorized Medicare Benefits be made either to me or on my behalf to Northside Gastroenterology for any services furnished me by their physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature of patient/guardian _____ Date

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Northside Gastroenterology for any services furnished me by their physicians. I authorize any holder of medical information to release to my Medigap insurance any information needed to determine these benefits payable for services.

Signature of patient/guardian _____ Date

I hereby authorize the release of any medical information necessary to process any and all of my claims, or facts concerning the treatment provided. I further authorize my insurance company to pay direct to Northside Gastroenterology the medical benefits otherwise payable to me. I understand that I am financially responsible for those charges not paid by my insurance. A photocopy of this authorization shall remain in effect until such time as revoked by me.

Signature of patient/guardian _____ Date