NORTHSIDE GASTROENTEROLOGY, INC. – PATIENT INFORMATION – PLEASE PRINT

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE NUMBER : (_____)_____ CELL PHONE NUMBER: (____)_____

MARITAL STATUS: M D S W SOCIAL SECURITY NUMBER: _____ GENDER: (M/F)

RACE:_____ PREFERRED LANGUAGE: _____

ETHNICITY: _____ Hispanic Latino _____ Not Hispanic Latino

EMPLOYER: _____ WORK PHONE: (_____)_____EXT. _____

EMERGENCY CONTACT/RELATIONSHIP: _____ PH #: (_____)_____

REFERRING PHYSICIAN: _____ PRIMARY CARE DOCTOR: _____

REASON FOR VISIT: _____

PAST/PRESENT MEDICAL CONDITIONS:_____

REVIEW OF SYSTEMS: Please CIRCLE yes/no if you have any of the following symptoms.

General:	Fevers	Weight Loss/Gain___lbs.	Night Sweats	Fatigue	
Gastrointestinal:	Persistant Nausea	Frequent Vomiting	Heartburn/Reflux	Difficulty Swallowing	
	Abdominal Pain	Bloating	Blood in Stools	Excessive Gas	
	Constipation	Diarrhea	Jaundice/Yellow Skin	Hemorrhoids	
Head, Ears, Eyes, Nose, Throat:	Headache	Vision Loss	Neck Pain	Swollen Glands	
Respiratory:	Cough	Difficulty Breathing	Bloody Sputum		
Cardiac:	Chest Pain	Shortness of Breath	Heart Skips Beats/Beats Too Fast		
Neurological:	Dizziness	Seizures	Stroke		
Psychiatric:	Anxiety	Depression			
Skin:	Itching	Bruising	Rash		
Musculoskeletal:	Muscle Pain	Muscle Swelling			
Hematology:	Blood Clots	Excessive Bleeding			

SOCIAL HISTORY:

Do you smoke?	Y	N	If yes, _____ packs a day for _____ years.
Previous Smoker?	Y	N	If yes, _____ packs a day for _____ years.
Do you drink alcohol?	Y	N	If yes, how many drinks a week _____.
Previous drinker?	Y	N	If yes, for how long? _____

FAMILY HISTORY (LIST MEDICAL CONDITIONS):

Father: _____ Mother: _____

Sister: _____ Brother: _____

Grandparents: _____

SURGERIES (Even as a child): _____

_____

PLEASE COMPLETE BOTH SIDES OF THIS FORM

MEDICATION RECONCILIATION

Include all prescriptions, vitamins and over-the-counter drugs taken on a regular basis.

Name of Medication	Dosage	Frequency

Allergies to Medications, Foods, or Seasonal (If no allergies, write NONE)	Reaction

Pharmacy Name: _____

Pharmacy Phone: (____)_____ **Pharmacy Address:** _____

Mail Order Pharmacy Name: _____ **Phone Number:** _____ **Fax Number:** _____

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 Northside Gastroenterology, Inc. I understand that I am financially responsible for those charges not paid by my insurance. A photocopy of this authorization shall be considered as valid as the original. This authorization shall remain in effect until such time it is revoked by me.

_____ _____

Signature of Patient/Guardian Date

PLEASE COMPLETE BOTH SIDES OF THIS FORM

NORTHSIDE GASTROENTEROLOGY

RELEASE OF INFORMATION

Name:_____DOB___/____/____

Due to HIPAA rules and regulations, we are not to release any of your medical information including diagnosis or records of any kind unless stated otherwise.

Please list individuals we may speak with regarding your care:

DO NOT INCLUDE PHYSICIANS

1. _____

2. _____

3. _____

If unable to reach me:

You may speak to anyone else that might answer? YES NO

You may leave a detailed message? YES NO

Email address: _____

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 Northside Gastroenterology, Inc. I understand that I am financially responsible for those charges not paid by my insurance. A photocopy of this authorization shall be considered as valid as the original. **This Release of Information will remain in effect until terminated by the patient in writing.**

Patient Signature_____ **Date**___/____/___