

PATIENT REGISTRATION FORM

PLEASE PRINT

Date: _____ Referring Physician: _____ Primary Care: _____

Patient's Name: Last _____ First: _____ M.I. _____

Address: _____ City: _____ State: _____

Zip: _____ Home Phone: _____ Cell: _____ Work: _____

Email: _____

Preferred Contact Method _____

Race: _____ Ethnicity: _____ Gender: M F Marital Status: M S W D

SSN: _____ / _____ / _____ D.O.B. _____ / _____ / _____

Pharmacy: _____ Pharmacy Location: _____

Employer: _____ Occupation: _____

Emergency Contact Name: _____ Phone: _____

Insurance Subscriber's Date of Birth if other than self: _____

PATIENT CONSENTS

I, the undersigned patient, understand I have the right to request a copy of Mobile Gastroenterology's Notice of Privacy Policy which pertains to my rights under HIPAA. Upon my request a copy shall be provided to me.

Signature of Patient/Authorized representative

Date

WITHOUT YOUR WRITTEN CONSENT, WE CAN NOT SPEAK TO ANYONE REGARDING YOUR MEDICAL CARE due to privacy laws. You have the right to list anyone you would like our staff to be able to speak with regarding your medical care. By listing their name below, you are giving your authorization for the physicians and staff of Mobile Gastroenterology to speak with them. If no one is listed, we are authorized only to speak with you, the patient.

Signature of Patient/Authorized Representative

Date

OVER PLEASE

RELEASE OF MEDICAL INFORMATION

I, the undersigned, as the patient or his/her authorized representative, do hereby authorize Mobile Gastroenterology, P.C., to release to my insurance company (ies) or other appropriate agency (ies) that information which is necessary to validate this claim. Mobile Gastroenterology, P.C., is also hereby authorized to release to my physician(s), either as an individual(s) or as a professional association, who perform services for me, the patient, on a fee for service basis such information as is necessary for billing purposes.

ASSIGNMENT OF INSURANCE AND FINANCIAL RESPONSIBILITY

I do hereby authorize payment of all insurance benefits, basic and major medical for these services, to be made directly to Mobile Gastroenterology, P.C. For and in consideration of services rendered, I hereby agree to pay Mobile Gastroenterology, P.C. for all charges not covered by insurance payments. I agree to pay all cost of collecting, securing, or attempting to collect or secure, including reasonable attorney fees or Collection Agency fees not exceeding 15% of the unpaid debt, whether suit be necessary or otherwise.

Until my accounts are settled, I give my direct consent to receive communications regarding my accounts from Mobile Gastroenterology, P.C., or collectors of my accounts, through various means such as 1)any cell, landline, or text number that I provide, 2)any email address that I provide, 3) auto dialer systems, 4) voicemail messages, and other forms of communications.

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any service furnished me by or in Mobile Gastroenterology, P.C., including physician’s services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services.

I authorize any holder of medical or other information about me to release any information needed for this or any related Medicaid claim to the Medical Fiscal Intermediary, the Medical Services Administration and/or to any other parties who may be liable for any of my Medicaid expenses.

AUTHORIZATION TO RELEASE MEDICAL REPORTS (INFORMATION) TO CONSULTING PHYSICIANS

I hereby authorize Mobile Gastroenterology, P.C. to release any information to physicians other than original referring physicians, who may be involved in my health care treatment, when requested by these physicians. By signing this consent, information will be given to requesting physician without further signed authorization.

CONSENT FOR MEDICAL SERVICES:

Permission is hereby granted to the authorities of Mobile Gastroenterology, P.C. for such medical procedures as may be deemed necessary by my attending physician, or whomsoever he or she may designate.

RESPONSIBILITY FOR PERSONAL PROPERTY:

I understand that Mobile Gastroenterology, P.C., does not assume responsibility for my personal property.

Signature of Patient/Authorized Representative

Date

PATIENT INTERVIEW FORM
Mobile Gastroenterology, P.C.

Office Use Only:

BP _____ P _____ H _____ WT _____

Patient Name: _____ Referring Doctor: _____

What is the reason for your visit today? _____

Please check any of these symptoms you are currently having:

<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Epigastric pain/indigestion	<input type="checkbox"/> Vomiting blood
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Gas and bloating	<input type="checkbox"/> Weight loss
<input type="checkbox"/> Blood in stool	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Trouble swallowing
<input type="checkbox"/> Blood in toilet tissue	<input type="checkbox"/> Hepatitis	
<input type="checkbox"/> Belching	<input type="checkbox"/> Jaundice	
<input type="checkbox"/> Change in bowel movements	<input type="checkbox"/> Nausea/Vomiting	
<input type="checkbox"/> Constipation	<input type="checkbox"/> Rectal bleeding	
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Rectal pain	

Have you ever had a Colonoscopy? **Y / N** If yes, **When?** _____ **Where?** _____

Have you ever had surgery? **Y / N** (if yes, please list below) **What type of surgery/When:**

Do you currently smoke? Y / N If yes, how often? _____	Marital Status: (Please circle) M S W D
Have you ever smoked? Y / N	
Type: <input type="radio"/> Cigarettes <input type="radio"/> Chewing tobacco For how many years? _____	

Do you drink alcohol? Y / N If yes, how often? (Please circle) Daily Weekly Monthly Yearly

Allergies: _____ No known allergies No known drug allergies

What are your current medications?

Family History: No knowledge of family history **Does anyone in your family have/had colon cancer?** Y / N
If yes, Who: _____

Major illnesses:

Mother: _____ Father: _____

Brother: _____ Sister: _____

Children: _____ Other: _____

Review of Systems *Please check all that currently apply*

General:

- Fatigue
- Weakness
- Fever

Eyes:

- Eye pain
- Redness
- Loss of vision
- Double or blurred vision
- Dryness

Ear/ Nose/ throat/ neck:

- Ear pain
- Loss of hearing
- Ringing in ears
- Nosebleeds
- Loss of smell
- Dryness
- Sore throat
- Hoarseness
- Sore tongue
- Sores in mouth
- Bleeding gums
- Loss of taste
- Bad breath
- Swollen glands
- Tender glands

Cardiovascular:

- Night sweats
- Pain in Chest
- Irregular Heart Beat
- Sudden Changes in Heart Beat
- Difficulty in Breathing at Night
- Swollen Legs or Feet
- High Blood Pressure
- Heart Murmur

Respiratory:

- Sleep apnea
- Shortness of Breath
- Cough
- Coughing up Blood
- Wheezing

Kidneys/Urine/Bladder:

- Dark urine
- Difficult urination
- Pain/Burning on Urination
- Blood in Urine
- Frequent urination
- Getting up at night to urinate
- Prostate trouble

Muscle/Bones:

- Joint Pain
- Muscle Weakness
- Muscle Tenderness
- Joint swelling
- Muscle Spasm

Skin:

- Blisters
- Easy Bruising
- Knot
- Redness
- Rash
- Hives
- Tightness
- Cysts
- Hair Loss

Nervous system:

- Seizures
- Headaches
- Dizziness
- Memory loss
- Fainting
- Loss of Consciousness
- Sensitivity or pain
in hands/feet

Blood:

- Anemia
- Bleeding tendency

Do you have:

- High blood pressure
- heart valve replacement
- Asthma
- Stroke
- Diabetes
- Kidney Disease
- Heart disease
- Defibrillator
- Pacemaker
- COPD/Emphysema
- Cancer _____ Type
- Thyroid disease
- Female/GYN problems
- High cholesterol

Patient

Signature: _____

Date: _____ Reviewed By: _____

APPOINTMENT AND PROCEDURE CANCELLATION POLICY

We are committed to providing all our patients with the finest clinical care, and we appreciate the opportunity to serve you.

Our physicians reserve a significant amount of time for your office visit or procedure, and our staff invests a great deal of time in scheduling and registering you for your appointment. Please understand that untimely cancellations in our schedule create problems for our office and deprives the opportunity of another patient making use of that appointment. Furthermore, it jeopardizes our ability to ensure you receive the medical care you need in a timely manner.

We realize that some patients may have an unavoidable need to change an appointment. However, we are requesting that when possible, you cancel your office visit or procedure in good time. The following provides Appointment Cancellation Policy:

- An office visit cancellation with less than 24 hours' notice will result in an administrative fee of **\$20** charged directly to you and not your insurance. The same fee will be charged on a no-show appointment.
- A procedure cancellation with less than 48 hours' notice will result in an administrative fee of **\$100** charges directly to you and not to your insurance. The same fee will be charged on a no-show appointment.
- Your next appointment will not be scheduled until this fee is paid. If more than two appointments are cancelled without notification, we will be unable to reschedule any office visits or procedures for you.

We hope you understand the need for this policy. Once again, thank you for allowing us to participate in your medical care.

Patient Signature

Date

Appointment Reminder Calls/Text Message Reminders

Our practice now utilizes text messaging to remind our patients of an upcoming appointment. It has been our experience our patients prefer to receive a text reminder rather than have a missed call not knowing what it was regarding. **If for any reason you prefer NOT to receive a text reminder or do not have a cell phone, please opt out by checking the first box below.** You will receive a reminder call instead. Otherwise, please place a check mark in the second box to acknowledge you will receive text message reminders for any future appointments.

I do not wish to receive text message reminders.
Please call to remind me of my appointments at this
number _____

I acknowledge that I will receive text message
reminders on the following cell phone number

(OVER PLEASE)