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: ____________________________________

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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:

_____ Abdominal pain	_____ Epigastric pain/indigestion	_____ Vomiting blood
_____ Anorexia	_____ Gas and bloating	_____ Weight loss
_____ Blood in stool	_____ Hemorrhoids	_____ Trouble swallowing
_____ Blood in toilet tissue	_____ Hepatitis	
_____ Belching	_____ Jaundice	
_____ Change in bowel movements	_____ Nausea/Vomiting	
_____ Constipation	_____ Rectal bleeding	
_____ Diarrhea	_____ 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? _____

Have you ever smoked? Y / N

Type: ⬭ *Cigarettes* ⬭ *Chewing tobacco* For how many years?_____

Marital Status: (*Please circle*)

M S W D

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)