PATIENT INFORMATION

Last name: ______________________ First name: ______________________ Middle initial______

Maiden name: ______________________ Sex: Male / Female Date of Birth: _____/_____/______

Address: ______________________ City: ______________________ State: ______ Zip: ________

Preferred Phone: (___) ________-_________(home/ cell/ work) 2nd Phone: (___) ______-________ Ext: ___ (home/ cell/ work)

Appointment confirmation method: (Phone Call/ Email /Text Message)

Social Security Number: ________-_________-_________ Marital Status: Single / Married / Divorced / Widowed

Email: ______________________ Patient Employer: ______________________

Primary Care Physician: ______________________ Phone: ______________________

We are mandated to collect and report to the State of Illinois the following information. Please circle below.

RACE: American Indian, Asian, African American, Native Hawaiian, Caucasian, Multi-Racial, Decline to answer.

Ethnicity: Hispanic, Non-Hispanic, Decline to answer.

PRIMARY INSURED- INFORMATION

Insured Last name: ______________________ First name: ______________________ Middle Initial: ______

Insured Date of birth: ______________________ Social Security Number: ______________________

Primary Insured Address: ______________________ City: ______________ State: ________Zip: ________

Preferred Phone: ______________________ Work phone: ______________ Insurance Plan name: ______________

ID# ______________________ Group # ______________________

Insured Employer name: ______________________ Relationship to patient: ______________________

SECONDARY INSURANCE- INFORMATION

Insured Last name: ______________________ First name: ______________________ Middle Initial: ______

Insured Date of birth: ______________________ Social Security Number: ______________________

Home phone: ______________________ Work phone: ______________ Insurance Plan name: ______________

ID# ______________________ Group # ______________________

Insured Employer name: ______________________ Relationship to patient: ______________________

EMERGENCY DATA INFORMATION- SOMONE NOT LIVING WITH PATIENT

Name: ______________________ Phone: ______________________ Relationship: ______________________

RELEASE OF PATIENT MEDICAL INFORMATION- AUTHRIZATION

I authorize Center for Gastrointestinal Health and Metroeast Endoscopy Surgery Center to discuss my medical care with the following family members or other individuals as designated below:

Name: ______________________ Phone: ______________________ Relationship: ______________________

Name: ______________________ Phone: ______________________ Relationship: ______________________

I authorize Center for Gastrointestinal Health and Metroeast Endoscopy Surgery Center to leave a message on my voice mail/ home answering machine or the above individuals: yes _____ no_____

Signature: ____ Date: _____/_____/______

PARENT/ GUARIAN OF MINOR CHILD- INFORMATION (<18 YEARS OF AGE)

LAST NAME: ______________________ FIRST NAME: ______________________ MIDDLE INITAIL______

MAIDEN NAME: ______________________ SEX: MALE / FEMALE Date of Birth: _____/_____/______

Address: ______________________ CITY: ______________________ State: ______ ZIP: ________

Preferred Phone (___) ______-_________ 2nd Phone: (______) ______-________ Ext: ______ (home/ cell/ work)

Social Security Number: ________-_________-_________ Email: ______________________

OFFICE POLICY

PAYMENT IS DUE AT THE TIME OF SEVICE ON ALL OFFICE VISITS UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. IF YOU ARE CURRENTLY ON MEDICARE, THIS OFFICE IS A PARTICIPATING PROVIDER. WE WILL FILE YOUR SECONDARY INSURANCE UNLESS OTHERWISE REQUESTED. ALL OTHER INSURANCE COERAGE IS FILED AS A COURTESY TO OUR PATIENTS UNLESS OTHERWISE REQUESTED. IF YOU ARE COVERED UNDER AN HMO PLAN, IT IS YOUR RESPONSIBILITY TO OBTAIN THE PROPER REFERRAL. YOU WILL BE RESPONSIBLE FOR ANY CHARGES THAT ARE NOT COVERED UNDER THE COMPANIES GUIDELINES OR CHARGES WHERE PROPER REFERRAL WAS NOT OBTAINED.

PATIENT INTIALS: ________

POLICY FOR NON-PAYMENT FOR SERVICES: IT IS OUR POLICY THAT ROUTINE HEALTCARE WILL NOT BE PROVIEDED IN THIS OFFICE WHEN A PATIENT HAS A HISTORY OF NON- PAYMENT FOR SERVICES. NON-PAYMENT FOR SERVICES IS DEFINED AS AN ACCOUNT ON WHICH A PATIENT BALANCE IS OUTSTANDING AND THERE HAS BEEN NO EFFORT BY EITHER THE PATIENT OR RESPONSIBLE PARTY TO MAKE PAYMENT ON THE ACCOUNT. ALTHOUGH ROUTINE HEALTHCARE WILL NOT BE PROVIDED, EMERGENCY CARE MAY BE PROVIDED.

PATIENT INITIALS: ________

IT IS OFFICE POLICY TO HAVE A NEW PATIENT REGISTRATION FORM COMPLETED EVERY TWO YEARS. THIS OFFICE MAY REQUEST UPDATED COPIES OF YOUR INSURANCE CARDS AT ANY TIME. PLEASE BRING YOUR INSURANCE CARDS WITH YOU AT EACH VISIT.

PATIENT INITIALS: ________

RELEASE AND ASSIGNMENT

DR. SHAKEEL AHMED
CENTER FOR GASTROINTESTINAL HEALTH
METROEAST ENDOSCOPY SURGERY CENTER
5023 NORTH ILLINOIS STREET
FAIRVIEW HEIGHTS, IL 62208

I HEREBY authorize Center for Gastrointestinal Health and Metroeast Endoscopy Surgery Center, TO RELEASE MY INSURANCE COMPANIES OR THEIR REPRESENTATIVES ANY INFOR MATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME.

I ALSO AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE Center for Gastrointestinal Health and Metroeast Endoscopy Surgery Center OR THE ABOVE PHYSICIAN THE AMOUNT DUE ME IN MY PENDING CLAIM FOR BASIC MEDICAL, MAJOR MEDICAL, AND/OR SURGICAL TREATMENT OR SERVICES BY REASON OF SUCH TREATMENT OR SERVICES RENDERERD TO ME.

I ALSO UNDERSTAND THAT I WILL BE HELD RESPONSIBLE FOR ANY COLLECTION COST, LAWYERS' FEES, AND ALL LEGAL FEES SHOULD MY ACOUNT BE SENT TO A COLLECTION AGENCY OR OTHER INSTITUTIONS FOR COLLECTIONS. I HAVE ALSO READ AND UNDERSTAND THE POLICY FOR NON-PAYMENT FOR SERVICES.

PATIENT SIGNATURE: ______________________________ DATE: ______________

WITNESS: ______________________________ DATE: ______________

CENTER FOR GASTROINTESTINAL HEALTH
Shakeel Ahmed, MD
Heather Smith ANP-BC
Jessica Gibson, PA-C
Interventional Gastroenterologist/ Hepatologist- Board Certified
5023 North Illinois street Suite 1
Fairview Heights, IL 62208
Office: 618-239-0678 Fax: 618-235-0471 Exchange: 618-398-9450

RECEIPT OF NOTICE OF PRIVACY PRACTICES FORM

I, ______________________________________, hereby acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the notice. I also understand that a copy of any revised notice will be provided to me or made available.

Signed: ____ Date: _______________
If you are not the patient, please specify your relationship to the patient: ___________________

Name ________________________________ Date of Birth: ____/____/____ age _____ Todays date ___________

Referring Physician: ___________________________________

Please briefly state the reason(s) you are being seen today.____

____

Medical Conditions/ Serious Illness/ Hospitalizations/ Surgeries with approximate dates

____

____

____

____

MEDICATIONS- including prescription, over-the-counter and vitamins or we can copy YOUR list.

Name, dose, frequency	Name, dose, frequency	Name, dose, frequency	Name, dose, frequency
____________________	____________________	____________________	____________________
____________________	____________________	____________________	____________________
____________________	____________________	____________________	____________________
____________________	____________________	____________________	____________________
____________________	____________________	____________________	____________________

Primary Pharmacy: ________________ Address: __________________________________Phone: (___) _____-_______

List any Allergic reactions to any Medications, Latex, etc.

____

FAMILY HISTORY

Has anyone in your family ever had:			Who?	Age at diagnosis
Colorectal Cancer:	NO	YES	____________________	____________________
Non-Cancerous Colon Polyps:	NO	YES	____________________	____________________
Crohn's or Ulcerative Colitis:	NO	YES	____________________	____________________
Celiac Disease:	NO	YES	____________________	____________________
Other Cancers:	NO	YES	____________________	____________________

SOCIAL HISTORY

Occupation: ______________________________ Who lives with you at home? ____________________

Do you currently or have you in the past used the following substances:

Cigarettes	yes	no	yes, but quit	#years smoked ______ How much per day__________
Alcohol	yes	no	yes, but quit	Amount: _______ Drinks per Day Week Month
IV Drugs	yes	no	yes, but quit	What kind__________________ how often______________
Other Illicit drugs	yes	no	yes, but quit	What kind__________________ how often______________

Have you traveled outside the country or been camping in the past year? No/Yes where______________________

REVIEW OF SYSTEMS

Please circle any symptoms that you are currently or have recently been experiencing.

General: lack of energy lack of appetite

HEENT: glaucoma, vision problems, hoarseness/sore throat, mouth ulcers

Cardiovascular: chest pain, irregular heartbeat, swollen feet

Respiratory: asthma, COPD, shortness of breath, history of OSA, use CPAP at night

Musculoskeletal: arthritis, joint pain, muscle aches

Gastrointestinal: stomach pain, nausea, vomiting, bloating, swallowing problems, heartburn, diarrhea, constipation, rectal bleeding, black stools, change in bowel habits, laxative use

Genitourinary: dark urine, kidney disease, excessive urination

Skin: bruising, itching, yellow skin, rashes

Endocrine: hot intolerance, diabetes, cold intolerance, thyroid disease

Neurologic: seizures, dizziness, fainting, numbness/tingling

Psychiatric: anxiousness, depression, difficulty sleeping, suicidal/homicidal ideations, under the care of mental health professional

Have you ever had a Colonoscopy? No Yes, where/when/with what Dr.____________________________________
Have you ever had an EGD? No Yes, where/when/with what Dr.____________________________________
Have you ever had an ERCP? No Yes, where/when/with what Dr. ____________________________________

Are you diabetic? Yes/No
Do you take any blood thinners? (Aspirin, Plavix, etc.)__________________________
Who prescribes them? DR:___________________ Number______________________

Do you see a specialist?	For?	Doctor Name:	Phone Number:
Neurologist/History of seizures			
Cardiologist/Heart			
Pulmonologist/Lungs			
Any other specialist?			

Do you suffer from any of the following symptoms? If so we can help!!
Please check any of the following rectal symptoms that you currently have or have had in the past.

__ Itching __Bleeding __Leakage __ Pressure __ Pain __Soiling

__ Swelling __ Skin irritation __ Fecal incontinence __ Seepage __ Burning

Bowel Symptom Questionnaire

Name: Date:

Doctor:

Which symptoms best describe you? Select all that apply.

Accidental loss or leakage of stool—sometimes unable to make it to the bathroom in time
Bowel accidents while unaware—no warning and/or while asleep
Frequent, loose, watery stools
Sudden or strong urge to go to the bathroom
Bowel accidents when passing gas
No bowel problems (if checked, please discontinue questionnaire)

How long have you had these symptoms?

Approximately how many bowel incidents do you have per week?

Have you tried medications to help your symptoms? Yes No

On a scale of 0 to 10, with 0 being no symptom relief and 10 being complete symptom relief, how much symptom relief have these medications provided for you? Select number.

0	1	2	3	4	5	6	7	8	9	10

No Relief *Complete Symptom Relief*

Behavior modifications tried?

(e.g., lifestyle changes, fiber, diet changes, physical therapy)

On a scale of 0 to 10, with 0 being no frustration at all and 10 being extremely frustrated, what is your level of frustration with your bowel control symptoms? Select a number.

0	1	2	3	4	5	6	7	8	9	10

Not Frustrated *Very Frustrated*

Are you interested in learning more about additional treatment alternatives to bowel medications?

Yes No