Center for

Digestive Health & Nutrition

Affiliated with the Three Rivers Endoscopy Center

Patient Information

Today's Date ____________________

First Name ____ Middle Initial ____ Last Name ____

Social Security Number ____ Age ____ Birthdate ____

Street Address ____ Township or Borough ____

City/State/Zip ____ Occupation ____

Email Address (in case we can't reach you by phone) ____

Home Phone ____ Work Phone ____ Cell Phone ____

Race/Ethnicity ____ Religion ____

Sex (check one): ❑ M ❑ F Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Name of Doctor or Person Who Referred You ____

Is Insurance in Your Name? ❑ Yes ❑ No If no, please complete the following:

Subscriber's First Name ____ Last Name ____ Birthdate ____

Subscriber's Relationship to You ____

Emergency Contact ____ Relationship ____

Address (if different) ____ Phone Number ____

City/State/Zip ____

Spouse's First Name ____ Last Name ____ Birthdate ____

Name of person to whom you authorize Center for Digestive Health & Nutrition and/or Three Rivers Endoscopy Center to release personal health information:

First Name ____ Middle Initial ____ Last Name ____

Patient's Signature ____

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Direction of Feed

Patient History

Please answer every question

STAFF: Responses in boxed bubbles and handwritten items must be entered **MANUALLY**.

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH
Month Day Year

Please complete this history form. This will allow us to serve your health needs.

The information contained herein is strictly confidential and will not be released unless you authorize us to do so.

Why are you here to see our providers?

Who is your PRIMARY CARE PHYSICIAN?

Who referred you?

What is your preferred pharmacy and location?

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MEDICATIONS

Please list any medications you are currently taking.

Include prescription medications, over the counter medications and any herbal supplements.

_____ **Please write your initials on the line if you are NOT CURRENTLY taking any medications.**

Name of Medication	Dosage	Frequency	Name of Medication	Dosage	Frequency

ALLERGIES

If you have NO KNOWN ALLERGIES, please initial here: ________

Are you allergic to any of these items? latex egg soy iodine / contrast allergies

If yes, please initial on the line below the allergen:

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Please list medications that have given you bad reactions and / or allergic reactions.

If possible, include your reactions – hives, rash, itching, shortness of breath, etc.

MARITAL STATUS ◯ single ◯ divorced ◯ married ◯ widowed

RACE ◯ Caucasian ◯ African American ◯ Asian ◯ Hispanic ◯ American Indian ◯ more than one race ◯ other

ETHNICITY ◯ Hispanic or Latino ◯ Not Hispanic or Latino ◯ unreported ◯ undefined

LANGUAGE ◯ English ◯ Spanish ◯ American Sign Language ◯ other

ANESTHESIA

Has a family member of yours had anesthesia problems post-surgery? yes ◯ no ◯

Have you personally had any problems with anesthesia post-surgery? yes ◯ no ◯

If yes, did you have any of these symptoms? nausea ◯ vomiting ◯ difficult intubation ◯

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Please answer every question

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CURRENT SYMPTOMS

Mark all symptoms you CURRENTLY have. If you have no symptom in a category, mark "**NONE**."

Category			
GENERAL	tiredness ◯ lack of appetite ◯	fever ◯ unintentional weight loss (over 10 lbs.) ◯	night sweats ◯ **NONE** ◯
HEAD, EARS, EYES, NOSE & THROAT	wear glasses ◯ wear contacts ◯	glaucoma ◯ decreased hearing ◯	hoarseness ◯ headache ◯ **NONE** ◯
CARDIOVASCULAR	elevated blood pressure ◯ fainting / blacking out ◯ swelling of hands or feet ◯	chest pain ◯ heart stent ◯ heart valve replacement ◯	pacemaker ◯ defibrillator ◯ **NONE** ◯
GENITOURINARY	painful urination ◯ frequent urination ◯	change in urinary stream ◯ pelvic pain ◯	blood in urine ◯ kidney disease ◯ **NONE** ◯
NEUROLOGICAL	difficult speech ◯ loss of consciousness ◯ weakness in extremities ◯	dizziness ◯ fainting ◯ seizure ◯	stroke ◯ **NONE** ◯

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Category			
ENDOCRINE	cold intolerance ◯ heat intolerance ◯	excessive thirst ◯ excessive urination ◯	thyroid problem ◯ **NONE** ◯
MUSCULOSKELETAL	physical disability ◯ joint stiffness ◯	arthritis ◯ backache ◯	**NONE** ◯
SKIN		rash ◯ itching ◯	**NONE** ◯
RESPIRATORY	chronic cough ◯ difficulty breathing ◯	documented sleep apnea ◯ use CPAP / BiPAP ◯	wheezing ◯ **NONE** ◯
PSYCHIATRIC		suicidal thoughts ◯ depression ◯	anxiety ◯ **NONE** ◯
BLOOD	easy bruising ◯ blood thinner ◯	anemia ◯ blood clots ◯	**NONE** ◯
BREAST		breast pain ◯ breast mass ◯	**NONE** ◯
GASTROINTESTINAL	nausea ◯ diarrhea ◯ gas / flatulence ◯ jaundice (yellow skin) ◯	change in bowel habits ◯ indigestion / reflux / heartburn ◯ difficult / painful swallowing ◯ pain with bowel movement ◯	vomiting ◯ abdominal pain ◯ constipation ◯ blood in stool ◯ **NONE** ◯

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Have you ever had a colonoscopy?	◯ yes	◯ no
Have you ever had an upper endoscopy?	◯ yes	◯ no

IMMUNIZATIONS

Please indicate if you have been immunized against the following. Mark all that apply. If none, mark "**NONE**."

◯ hepatitis A ◯ hepatitis B ◯ flu ◯ pneumonia ◯ **NONE**

PERSONAL AND SOCIAL HISTORY

Who do you live with? (Mark all that apply)	◯ alone ◯ spouse / partner	◯ parents ◯ other	
Do you consume alcohol?	◯ never	◯ in the past	◯ currently
What is your smoking status?	◯ currently (every day) ◯ currently (some days)	◯ previous ◯ never	

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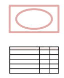
Direction of Feed

Patient History

Please answer every question

*STAFF: Responses in boxed bubbles and handwritten items must be entered **MANUALLY**.*



YOUR MEDICAL HISTORY

Please indicate if YOU have had any of the following. Mark all that apply. If none, mark "NONE."

- ◯ abnormal heartbeat / palpitations
- ◯ acid reflux / GERD
- ◯ alcohol abuse
- ◯ anemia
- ◯ anxiety
- ◯ arthritis
- ◯ asthma
- ◯ barrett's esophagus
- ◯ bleeding disorder
- ◯ blood clots
- ◯ bowel obstruction
- ◯ breast cancer
- ◯ celiac disease
- ◯ chronic constipation
- ◯ diverticulosis
- ◯ emphysema or COPD
- ◯ esophageal stricture or narrowing
- ◯ esophageal cancer
- ◯ fibromyalgia
- ◯ gallstones
- ◯ glaucoma
- ◯ gout
- ◯ hearing impairment
- ◯ heart disease
- ◯ heart attack
- ◯ hemorrhoids
- ◯ hepatitis C
- ◯ high blood pressure
- ◯ migraines
- ◯ osteoporosis
- ◯ ovarian cancer
- ◯ pancreatitis
- ◯ prostate cancer
- ◯ seizure disorder
- ◯ skin cancer
- ◯ staph / MRSA infection
- ◯ sleep apnea
- ◯ stomach ulcer or duodenal ulcer
- ◯ stroke
- ◯ thyroid disease
- ◯ treatment with blood thinner
- ◯ ulcerative colitis

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- ◯ colon or rectal cancer
- ◯ colon polyps
- ◯ Crohn's disease
- ◯ dementia
- ◯ depression
- ◯ diabetes
- ◯ HIV positive
- ◯ irritable bowel syndrome
- ◯ jaundice / yellow skin as an adult
- ◯ kidney problems
- ◯ liver failure / cirrhosis
- ◯ lupus
- ◯ uterine cancer
- ◯ other
- ◯ **NONE**

SURGERIES

Please indicate if YOU have had any of the following. Mark all that apply. If none, mark "**I HAVE HAD NO SURGERIES**."

- ◯ aortic aneurysm repair
- ◯ appendectomy
- ◯ automatic cardiac defibrillator
- ◯ back surgery
- ◯ brain surgery
- ◯ colon surgery
- ◯ coronary artery bypass graft
- ◯ gallbladder removal
- ◯ gastric resection
- ◯ heart valve replacement
- ◯ hiatal hernia surgery
- ◯ hip replacement
- ◯ hysterectomy (partial)
- ◯ hysterectomy (total)
- ◯ knee surgery
- ◯ pacemaker placement
- ◯ prostate surgery
- ◯ shoulder surgery
- ◯ stomach ulcer
- ◯ tubal ligation
- ◯ TURP
- ◯ weight loss surgery
- ◯ vasectomy
- ◯ defibrillator
- ◯ other
- ◯ **I HAVE HAD NO SURGERIES**

Please list any additional conditions, diseases and surgeries you have not shown above.

____

____

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FAMILY HISTORY

◯ **FAMILY HISTORY UNKNOWN**

Have any of your first degree relatives had Colon Cancer? [parent(s), brother(s) or sister(s)] **If "yes", who?**

◯ **yes** ◯ **no** ◯ mother ◯ father ◯ brother ◯ sister ◯ other

Have any of your first degree relatives had Colon Polyps? [parent(s), brother(s) or sister(s)] **If "yes", who?**

◯ **yes** ◯ **no** ◯ mother ◯ father ◯ brother ◯ sister ◯ other

Please indicate if YOUR FAMILY has a history of the following.

Only include parents, grandparents, siblings and children. Mark all that apply. If none, mark "NONE."

- ◯ alcohol abuse
- ◯ autoimmune hepatitis
- ◯ bleeding disorder
- ◯ blood clots
- ◯ breast cancer
- ◯ cancer, other
- ◯ celiac disease
- ◯ cirrhosis
- ◯ Crohn's disease
- ◯ diabetes
- ◯ heart attack
- ◯ hemachromatosis
- ◯ hepatitis B
- ◯ hepatitis C
- ◯ hypertension
- ◯ irritable bowel syndrome
- ◯ liver cancer
- ◯ mental Illness
- ◯ ovarian cancer
- ◯ pancreatitis
- ◯ prostate cancer
- ◯ sickle cell
- ◯ stomach cancer
- ◯ stroke
- ◯ tuberculosis (TB)
- ◯ ulcerative colitis
- ◯ ulcer disease
- ◯ uterine cancer
- ◯ other
- ◯ **NONE**

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CENTER FOR DIGESTIVE HEALTH & NUTRITION
AND
THREE RIVERS ENDOSCOPY CENTER

Consent For Treatment and Payment Agreement

CONSENT FOR MEDICAL CARE

I,____________________________, consent to medical evaluation and treatment by the physicians and employees of the Center For Digestive Health & Nutrition and Three Rivers Endoscopy Center. I understand that my medical evaluation and treatment may include certain diagnostic tests. In addition, my physician may determine that certain invasive procedures are necessary. I understand that I may discuss my medical treatment with my physician and may withdraw my consent if I so desire.

Signed____ Date__________________________

Relationship (parent/guardian)____

FINANCIAL ARRANGEMENTS/RELEASE OF INFORMATION

1. I agree to the following terms with respect to payment for all services provided.

   A. I authorize the **Center For Digestive Health & Nutrition/Three Rivers Endoscopy Center** to bill my insurance carrier and request such payments be made directly to the **Center For Digestive Health & Nutrition/Three Rivers Endoscopy Center.** I certify that the information given by me with respect to insurance coverage or other payment sources is correct.

   B. I assign the **Center For Digestive Health & Nutrition/Three Rivers Endoscopy Center** all rights to insurance payments or other benefits to which I may be entitled for the services rendered.

   C. I authorize the **Center For Digestive Health & Nutrition/Three Rivers Endoscopy Center** to release any medical information about this treatment or service, if required, in order to obtain payment from my insurer or other payor as well as any such records or information as may be required by my insurer.

2. I understand that any amounts not paid by my insurance, including co-payments and deductibles, are my responsibility. I agree to pay the full charge for all services rendered by the **Center For Digestive Health & Nutrition/Three Rivers Endoscopy Center** at the time of service.

   *Upon your request, a Patient Account Representative will discuss charges you will encounter for services provided.

Guarantor Signature for Financial Arrangements__________________________________ Date__________________________

MEDICARE LIFETIME ASSIGNMENT

I request that payment of authorized Medicare Benefits be made on my behalf to the **Center For Digestive Health & Nutrition/Three Rivers Endoscopy Center** for any service(s) furnished to me by that provider. 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 benefits or the benefits payable for related services.

Signed____ Date__________________________

HIPAA ACKNOWLEDGEMENT AND CONSENT

I have received the Notice of Privacy Practices for the Center For Digestive Health & Nutrition and/or Three Rivers Endoscopy Center. The Center for Digestive Health & Nutrition and/or Three Rivers Endoscopy Center is authorized to use and disclose health information about________________________________ (patient name) for treatment, payment, and healthcare operations purposes consistent with its Notice of Privacy Practices.

Signature of Patient____ Date__________________________
(OR patient's personal representative)

Name of Personal Representative____________________________________ Relationship to Patient__________________________
(or other authority)