

PATIENT HEALTH HISTORY

Reason for visit _____

Describe your symptoms: _____

Please indicate yes or no if you have any of the symptoms listed below. Do you now, or do you have a history of:

GASTROINTESTINAL

- Poor appetite Yes No
- Difficulty in swallowing Yes No
- Heartburn Yes No
- Nausea or vomiting Yes No
- Bloating Yes No
- Belching Yes No
- Regurgitation Yes No
- Constipation Yes No
- Diarrhea Yes No
- Abdominal pain Yes No
- Changes in bowel habits Yes No
- Rectal bleeding Yes No
- Black, tarry stools Yes No
- Jaundice Yes No
- Liver Disease Yes No
- Ulcer Yes No

CONSTITUTIONAL

- Recent weight change Yes No
- Fever Yes No
- Fatigue Yes No
- Night Sweats Yes No

EYES

- Blurred vision Yes No
- Glaucoma Yes No
- Infections/Injuries Yes No

EARS/NOSE/MOUTH

- Hearing loss Yes No
- ringing in ears Yes No
- Mouth sores Yes No
- Sore throat Yes No
- Loss of balance Yes No

CARDIOVASCULAR

- Chest pain Yes No
- Shortness of breath Yes No
- Swelling of ankles/feet Yes No
- High blood pressure Yes No
- Irregular pulse Yes No
- Heart murmur Yes No
- High cholesterol Yes No

RESPIRATORY

- Chronic cough Yes No
- Spitting up blood Yes No
- Wheezing Yes No
- Asthma Yes No
- Emphysema Yes No
- Pneumonia/Bronchitis Yes No

SKIN

- Rash Yes No
- Itching Yes No

GENITOURINARY

- Burning with urination Yes No
- Blood in urine Yes No
- Frequent/urgent urination Yes No
- Incontinence Yes No

NEUROLOGICAL

- Headaches Yes No
- Seizures Yes No
- Strokes Yes No
- Numbness Yes No
- Disorientation Yes No
- Weakness Yes No
- Double/blurred vision Yes No
- Fainting spells Yes No
- Speech difficulty Yes No
- Coordination Yes No

ENDOCRINE

- Heat or cold intolerance Yes No
- Excessive thirst / urination Yes No
- Thyroid disease Yes No
- Diabetes Yes No

HEMATOLOGICAL

- Bleeding/bruising Yes No
- Anemia Yes No
- Blood transfusion Yes No
- Swollen glands Yes No

MUSCULOSKELETAL

- Joint/muscle pain Yes No
- Muscle pain Yes No
- Arm/leg weak/numbness Yes No
- Back/neck pain Yes No
- Arthritis Yes No

PSYCHIATRIC

- Memory loss or confusion Yes No
- Depression Yes No

REVIEWED	
DATE	BY
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize the Troy Gastroenterology, P.C., The Center for Digestive Health to receive or release the any medical or other information that may be necessary for the medical care or in processing insurance applications. This includes the sharing of information with all parties involved in my care, such as nursing care facilities, physicians, and hospitals. All means may be utilized, including electronic transmission. I authorize the release of my medical information to the following family members:

I understand that by signing this form, the above named individuals will receive my medical information by any means of transmission. This release is indefinite and if need be voided, I will do so in writing and request a new form.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of medical health benefits to Troy Gastroneterology, P.C., The Center for Digestive Health, for services rendered by one of their physicians or for services rendered under the supervision of a physician. I authorize any holder of medical or other information about me to release to the health insurance company any information needed to determine these benefits for related services. I understand that I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION FOR MEDICARE AND MEDICAID

I certify that the information given to me in applying for payment is correct. I authorize the release of all records on request. I request that payment of authorized benefits be made on my behalf.

PATIENT NAME: _____

PATIENT SIGNATURE: _____

DATE: _____

GUARDIAN (PRINT): _____

SIGNATURE: _____

WITNESS (PRINT): _____

SIGNATURE: _____

OFFICE AND FINANCIAL POLICY

OFFICE HOURS:

Regular office hours are 8:30 am to 5 pm Monday through Friday. The telephone system is shut down at 4:30 pm to facilitate the patient call-backs from the previous day. Office visits are by appointment only. We strongly believe in the value of your time and will do our best to keep scheduled appointments running smoothly. However, emergencies do occur and may cause a delay.

TELEPHONE CALLS:

The telephone calls are answered by a voice messaging system that allows for the correct transfer to the department of your choosing. A receptionist handles incoming calls, which allows for the physician to attend to their scheduled patients with a minimum of interruptions. The receptionist will take your information and leave a message for physician or the nurse. You non-urgent calls will be responded to within 48 hours. Prescription refill requests will be processed in two business days.

FEES AND PAYMENTS:

Our practice is committed to providing you with the best possible treatment and we charge what is customary in our area. Full payment is expected at the time of service by Cash, Check, Visa or MasterCard, unless arrangements are made prior to your visit with our billing department. There is a service charge of \$2.00 per month for all accounts not paid in full within 30 days.

INSURANCES:

If you have insurance coverage, please understand that this is a contract between you and your insurance company. As a courtesy to you, we will help you receive your benefits by submitting medical claims for reimbursement provided that we receive all the necessary information. PLEASE NOTE THAT SOME SCREENING PROCEDURES MAY NOT BE COVERED. CHECK WITH YOUR INSURANCE COMPANY BECAUSE YOU WILL BE RESPONSIBLE FOR PAYMENT IN FULL.

We participate with Medicare, Blue Cross Blue Shield of Michigan, and selected PPO and HMO companies which may require a deductible or co-payment to be met. It is your responsibility to make sure that we are a contracted provider with your insurance company. Also, that you have all necessary referral and authorization information with you at the time of service. It is your responsibility to know your individual coverage and to supply us with the correct information. If you need to have any laboratory work, radiology, or other testing, it is your responsibility to inform our office if the testing needs to be done at a specific location or if pre-authorization is required.

MISSED APPOINTMENTS:

Unless we receive a 24-hour notice of cancellation of your appointment, our policy is to charge for missed appointments at the rate of a normal office visit. To help better serve you, please keep your scheduled appointments.

MINOR PATIENTS:

The adult accompanying a minor or the parents/guardians are responsible for full payment. For an unaccompanied minor, non-emergent care will be denied, unless arrangements have been made ahead of time with our billing department. A minor child must arrive at the office with a permission note with the date of service listed and a telephone number where a parent/guardian may be reached to verify the request.

I understand and agree to the above Office and Financial Policies.

PATIENT SIGNATURE: _____

DATE: _____

OR RESPONSIBLE PARTY

TODAYS DATE: _____



CENTER FOR DIGESTIVE HEALTH

4600 Investment Drive, Suite 380

Troy, MI 48089

Phone: (248) 267-5025

Fax: (248) 267-5026

PATIENT INFORMATION

Please complete the following form and bring it with you on the day of your scheduled appointment.

1701 E. South Boulevard, Suite 300

Rochester Hills, MI 48307

Phone: (248) 844-9710

Fax: (248) 844-9711

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: Home _____ Work _____ Other _____

Patient ID #: _____ Birthdate: _____ Sex: Male Female

Social Security #: _____ Marital Status: Single Married Divorced

Referring Physician: _____ Phone #: _____

Primary Physician: _____ Phone #: _____

Spouse/Guardian: _____ Phone #: _____

Emergency Contact _____ Phone #: _____

Nearest Relative Not Living With You: _____ Phone #: _____

Drivers License #: _____

PATIENT EMPLOYMENT Employment Status: Employed Retired Other

Employer: _____ Phone #: _____

Guarantor: _____ Address: _____ City, State, Zip: _____

SPOUSE EMPLOYMENT Employment Status: Employed Retired Other

Employer: _____ Phone #: _____

Social Security #: _____ Birthdate: _____

PRIMARY INSURANCE COMPANY Same as Patient Same as Guarantor Other

Insured's Name: _____ Relationship to Patient: _____

Insured's Phone #: _____ Insurance Company _____

Contract / I.D. #: _____ Policy Group #: _____ Birthdate: _____

SECONDARY INSURANCE COMPANY Same as Patient Same as Guarantor Other

Insured's Name: _____ Relationship to Patient: _____

Insured's Phone #: _____ Insurance Company _____

Contract / I.D. #: _____ Policy Group #: _____ Birthdate: _____

Patient Name: _____ Date: _____

MEDICATIONS

Please list all medications you are currently taking. Please include dosage and usage of each medication.

MEDICATION NAME	DOSE	FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES

Please list all allergies

ILLNESS OR OPERATIONS

Please list all major illnesses and operations

CONSUMPTION

The following are important to GI disorders. Please indicate your consumption of:

	DO YOU CONSUME?	HOW OFTEN?	AMOUNT
Aspirin	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Nicotine	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Caffeine	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____

Have you ever been seen at William Beaumont Hospital? Yes No

Have you ever had?: Upper GI Barium Enema Ultrasound

If yes, where? _____

FAMILY HISTORY

Please complete the following information for your blood relatives:

	DECEASED?	AGE	HEALTH STATUS / CAUSE OF DEATH
Father:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Mother:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Brother:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Sister:	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____