ENDOSCOPY CENTER OF OCALA, INC.
GASTROENTEROLOGY ASSOCIATES

PATIENT INFORMATION RECORD

TODAY'S DATE: _____

Miss
Mrs.
Name: Mr._____, _____ _____ SS#: _____-_____-_____
(Last) (First) (MI)

Address: _____ _____ _____ _____
(Street) (City) (State) (Zip)

Telephone: Home:_____ Work:_____ Cell:_____

Date of Birth: _____ Sex: _____F _____M Email:_____

Racial Background:
(Circle one)

1. Asian or Pacific Islander
2. Black
3. Caucasian
4. Hispanic
5. American Indian or Alaskan Native
6. Black (Non-Hispanic)
7. White (Non-Hispanic)
8. Mutually Defined
9. Other

Ethnicity (Circle One): Hispanic or Latino Non-Hispanic or Latino Unknown

Marital Status:
(Circle one)

1. Single 2. Married 4. Widowed 5. Divorced 6. Legally Separated 7. Life Partner

If married, partner's name:_____

Should an **emergency** arise, please provide us with the name/telephone number of the person(s) we should call:
Name:_____ Telephone number:_____
Name:_____ Telephone number:_____

____The Referring Physician.....Name:_____
City/State_____
____My Family Physician .....Name:_____
City/State:_____
____Other.....Name:_____
City/State:_____

INSURANCE INFORMATION

Do you have Medicare Insurance? _____Yes _____No
If "Yes", what is your Medicare number? _____

If "No", what is the name of your insurance carrier:_____
Insurance address:_____
Group #:_____ ID#:_____
Subscriber's name:_____ DOB:_____ SS#:____-____-_____

If you have a Secondary Insurance, what is its name: _____
Insurance address:_____
Group #:_____ ID#:_____
Subscriber's name:_____ DOB:_____ SS#:____-____-_____

Does your insurance require pre-admission certification? _____Yes _____No
If "Yes", please provide us with the telephone number: (_____)_____

Medicare law requires that we determine if your medical services might be covered by another insurer. In order to assist us in correct billing procedures, please answer the following questions:

(1.) Is your illness due to
- A. A work-related accident/condition? _____Yes _____No
- B. An automobile accident? _____Yes _____No
- C. The fault of another party? _____Yes _____No

(2.) Are you eligible for coverage under the Veterans' Administration? _____Yes _____No

(*3) Are you a student? _____Yes _____No
If "Yes", are you a Full-Time Student? _____Yes _____No

(*4) Are you employed? _____Yes _____No
If "Yes", employer's name:_____
Employer's address:_____

If "No", please provide date of retirement if applicable:_____

(5.) Is your spouse employed? _____Yes _____No
If "Yes", please provide us with your spouse's name:_____
Spouse's employer name:_____
Spouse's employer address:_____

If "No", please provide date of retirement if applicable:_____

***PLEASE READ CAREFULLY** **In consideration for services rendered by Gastroenterology Associates/Endoscopy Center of Ocala, I hereby agree to release the information requested, as needed, by my insurance company and assign insurance benefits to Gastroenterology Associates/Endoscopy Center of Ocala. I further agree to be solely responsible for any balances my insurance carrier does not pay.**

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING AND IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT.

SIGNATURE:_____ DATE:_____

RELATIONSHIP TO PATIENT:_____

I request that payment of authorized Medigap benefits be made on my behalf to Gastroenterology Associates / Endoscopy Center of Ocala, Inc., for any services rendered by Gastroenterology Associates / Endoscopy Center of Ocala, Inc.

SIGNATURE:_____

PROTECTING YOUR MEDICAL HEALTH INFORMATION: **It is your right to control access and disclosure of your health information. Please list the names of family members and/or friends with whom we may share your medical information and/or lab results. DUE TO PRIVACY LAWS, WE WILL NOT GIVE ANY INFORMATION TO ANYONE WHO IS NOT ON THIS LIST!**

NAME(S): _____

_____

NOTIFICATION OF TEST RESULTS: Please call our office if you have not been notified of a test result by 14 days of having the test performed.

YOUR SIGNATURE: _____

Name Date

Reason For Visit

Allergies

- ⬭ Patient has no known drug allergies
- ⬭ Latex
- ⬭ Other_____
- ⬭ Other_____
- ⬭ Patient has no known allergies
- ⬭ Other_____
- ⬭ Other_____
- ⬭ Other_____

Current Prescription Medications & Over-the-Counter

⬭ None

Name	Dose	How Taken

Pharmacy – List preferred local

Name Address PH#

Diagnostic Studies/Tests – Done in the last year

⬭ None

⬭ CT of _____ When:_____

⬭ MRI of _____ When:_____

⬭ PET Scan When:_____

⬭ Other:_____ When:_____

Previous Procedures / All Surgeries (Please list all – especially abdominal surgeries)

⬭ None

⬭ Colonoscopy	⬭ Upper Endoscopy	⬭ Sigmoidoscopy	⬭ ERCP	⬭ Lung Surgery
When:_____	When: _____	When: _____	When: _____	When: _____
⬭ Blood Transfusion	⬭ Pacemaker	⬭ Artificial Heart Valve	⬭ Heart Bypass	⬭ Defribillator
When: _____	When: _____	When: _____	When: _____	When: _____
⬭ Stents	⬭ Hysterectomy	⬭ Gallbladder Surgery	⬭ Appendectomy	⬭ Other: _____
When: _____	When: _____	When: _____	When: _____	When: _____
⬭ Other: _____	⬭ Other: _____	⬭ Other: _____	⬭ Other: _____	⬭ Other: _____
When: _____	When: _____	When: _____	When: _____	When: _____

Name Date

Past or Present Medical Conditions

☐ None

☐ A. Fib When: _____	☐ Anemia When: _____	☐ Anesthesia Difficulties When: _____	☐ Asthma When: _____	☐ Barrett's When: _____
☐ Bleeding Problems When: _____	☐ Breast Cancer When: _____	☐ Cirrhosis When: _____	☐ Colitis When: _____	☐ Colon Cancer When: _____
☐ Colon Polyps When: _____	☐ COPD When: _____	☐ Crohn's Disease When: _____	☐ Diabetes Mellitus When: _____	☐ Dialysis When: _____
☐ Diverticular Bleed When: _____	☐ Diverticulosis When: _____	☐ Emphysema When: _____	☐ Epilepsy When: _____	☐ Gallstones When: _____
☐ GI Bleeding When: _____	☐ Glaucoma When: _____	☐ Hemorrhoids When: _____	☐ Hepatitis When: _____	☐ High Blood Pressure When: _____
☐ Kidney Stones When: _____	☐ Lung Cancer When: _____	☐ Mental Illness/Depression When: _____	☐ Pancreatitis When: _____	☐ Prostate Cancer When: _____
☐ Rheumatic Fever When: _____	☐ Restless Leg When: _____	☐ Sleep Apnea When: _____	☐ Stroke or TIA When: _____	☐ Thyroid Disease When: _____
☐ Tuberculosis When: _____	☐ Ulcerative Colitis When: _____	☐ Unusual Bleeding Tendencies When: _____	☐ Other: _____ When: _____	☐ Other: _____ When: _____

Social History

Occupation/Current:_____ Former(if Retired):_____

Alcohol ☐ None

Type	Quantity	Frequency
☐ Beer		times / day
☐ Wine	Glasses	times / day
☐ Liquor	Shots	times / day

Tobacco

Smoking Status ☐ Current Every Day Smoker ☐ Current Some Day Smoker ☐ Former Smoker ☐ Smoker, current status unknown ☐ Unknown if ever smoked ☐ Never Smoker

Type	Started	Quit	Quantity	Frequency
☐ Cigarettes				cigarettes / day
☐ Cigar				times / day
☐ Pipe				times / day
☐ Smokeless				times / day

Family Medical History

	Current Age			Age at Diagnosis
Mother		Colon Cancer ○ Yes ○ No Colon Polyps ○ Yes ○ No	Digestive Disorders ○ Yes ○ No Liver Disease ○ Yes ○ No	
Father		Colon Cancer ○ Yes ○ No Colon Polyps ○ Yes ○ No	Digestive Disorders ○ Yes ○ No Liver Disease ○ Yes ○ No	
Sister(s)		Colon Cancer ○ Yes ○ No Colon Polyps ○ Yes ○ No	Digestive Disorders ○ Yes ○ No Liver Disease ○ Yes ○ No	
Brother(s)		Colon Cancer ○ Yes ○ No Colon Polyps ○ Yes ○ No	Digestive Disorders ○ Yes ○ No Liver Disease ○ Yes ○ No	
Daughter(s)		Colon Cancer ○ Yes ○ No Colon Polyps ○ Yes ○ No	Digestive Disorders ○ Yes ○ No Liver Disease ○ Yes ○ No	
Son(s)		Colon Cancer ○ Yes ○ No Colon Polyps ○ Yes ○ No	Digestive Disorders ○ Yes ○ No Liver Disease ○ Yes ○ No	

Name Date

Review of Systems – Have you had any of the following symptoms within the ***past 2 months***

Cardiovascular	Yes	No
Chest Pain	○	○

Constitutional	Yes	No
Significant or unexplained weight loss	○	○
Significant weight gain	○	○

ENMT	Yes	No
Difficulty Swallowing	○	○
Nose Bleeds	○	○

Endocrine	Yes	No
Heat Intolerance	○	○

Gastrointestinal	Yes	No
Jaundice, yellow eyes, and/or skin	○	○
Rectal Bleeding	○	○
Black tarry stools	○	○

Genitourinary	Yes	No
Blood in Urine	○	○

Hematologic/Lymphatic	Yes	No
Unusual or excessive bleeding tendency	○	○
Prolonged bleeding/abnormal clotting	○	○
Excessive, prolonged, or abnormal bleeding associated with **any** past surgical procedures	○	○

Skin	Yes	No
Allergies, particularly to latex or tape	○	○
Rashes	○	○

Neurological	Yes	No
Seizures	○	○

Respiratory	Yes	No
Trouble breathing/shortness of breath	○	○
Coughing up blood	○	○
Use of home oxygen	○	○