

**Gastroenterology Clinic, Inc.**  
 611 Grammont Street • Monroe, LA 71201  
 (318) 325-2634

PATIENT ACCT. NO.		TRACKING NO.		TODAY'S DATE		PHYSICIAN	
PATIENT NAME						HOME PHONE NO.	
PATIENT ADDRESS						CITY	ST
						ZIP CODE	
DATE OF BIRTH	MARITAL STATUS	SEX	SOCIAL SECURITY #		REFERRING PHYSICIAN		
IN CASE OF EMERGENCY CALL (OTHER THAN SPOUSE)				EMERGENCY CONTACT PHONE #			
PATIENT'S EMPLOYER						BUSINESS PHONE NO.	
SPOUSE'S NAME			SPOUSE'S EMPLOYER			SPOUSE'S WORK PHONE NO.	
SPOUSE'S SOCIAL SECURITY #			SPOUSE'S DATE OF BIRTH				
PRIMARY INSURANCE CARRIER			POLICY NO.			GROUP NO.	
POLICY HOLDER			DATE OF BIRTH	GROUP NAME			
SECONDARY INSURANCE CARRIER			POLICY NO.			GROUP NO.	
POLICY HOLDER			DATE OF BIRTH	GROUP NAME			

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN	MEDICARE AUTHORIZATION
I hereby authorize payment of surgical and/or medical benefits to Gastroenterology Clinic, Inc. and further convey, transfer and assign all of my rights in my insurance coverage to Gastroenterology Clinic, Inc., for service rendered. I also hereby assign and transfer any and all rights, title, and interest to any claim for penalties and/or attorney fees arising under any state or federal law or regulation related to the payment of any claim for benefits to Gastroenterology Clinic, Inc. Regardless of the extent of the insurance coverage, I agree to be responsible for the entire balance. I also authorize release of information pertaining to my claim to my insurance company and/or companies or my attorney. Once the physician has obtained the patient's one-time authorization, he may submit any later claim on either an assigned or unassigned basis without obtaining any additional signature from the patient. In submitting claims, he should indicate "Patient request for payment on file." I hereby authorize Gastroenterology Clinic to furnish information to any requesting physician.	I certify that the information given by me in applying for a payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf once the physician has obtained the patient's one time authorization, he may submit any later Medicare claim on either an assigned or unassigned basis without obtaining any additional signature from the patient in submitting claims, he should indicate "Patient request for payment on file."
X _____ Date: _____	X _____ Date: _____

**GASTROENTEROLOGY CLINIC, INC.**  
**ENDOSCOPY CENTER OF MONROE**  
**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT**

I, (patient name) \_\_\_\_\_, acknowledge receipt of the *Notice of Privacy Practices*.

By \_\_\_\_\_ Date: \_\_\_\_\_  
**Signature of Patient or Representative**

I, (provider) \_\_\_\_\_, certify that I have made a good faith effort to obtain written acknowledgment of the patient's receipt of the *Notice of Privacy Practices*, but the acknowledgment was not obtained because:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

By: \_\_\_\_\_ Date: \_\_\_\_\_  
**Signature of Provider**

**This document must be retained in the patient's chart for the longer of 6 years from the date of its creation or when it was last in effect.**

PATIENT HISTORY FORM

NAME \_\_\_\_\_ DATE \_\_\_\_\_

AGE \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ REFERRING DOCTOR \_\_\_\_\_

I. MAIN COMPLAINT - THE MAIN REASON YOU ARE SEEING THE DOCTOR TODAY: Check Only One

- Abnormal Liver Tests, Constipation, GERD-Heartburn-Indigestion, Painful Swallowing, Bloating, Diarrhea, Hepatitis, Positive Stool Cards, Blood in Stool, Difficulty Swallowing, Lower Abdominal Pain, Upper Abdominal Pain, Change In Bowel Habits, Fever, Nausea, Weight Loss, Other, Vomiting

II. OTHER SYMPTOMS YOU ARE HAVING: PLEASE CIRCLE YES OR NO

- Bloating, Blood in Stool, Change in Bowel Habits, Constipation, Diarrhea, Difficulty Swallowing, Fever, Lower Abdominal Pain, Nausea, Painful Swallowing, Upper Abdominal Pain, Weight Loss. Each with Yes - No options.

What specific concerns or questions would you like the physician to address? (Fear of cancer, hepatitis, etc.)

III. REVIEW OF SYSTEMS - IF YOU ARE CURRENTLY EXPERIENCING: PLEASE CIRCLE YES OR NO

CONSTITUTIONAL

- Fatigue, Fever, Loss of Appetite, Night Sweats, Rigors, Weight Loss, Weight Gain, Other. Each with Yes - No options.

EYES

- Eye Pain, Sudden Change in Vision, Other. Each with Yes - No options.

EARS-NOSE-MOUTH-THROAT

- Bad Breath, Ears Ringing, Hearing Loss, Hoarseness, Nose Bleeds, Post Nasal Drip, Sore Throat, Other. Each with Yes - No options.

RESPIRATORY

- Cough, Shortness of Breath, Wheezing, Other. Each with Yes - No options.

CARDIOVASCULAR

- Chest Pain, Edema, Palpitation, Other. Each with Yes - No options.

GENITOURINARY

- Blood in Urine, Difficulty Starting Urine Stream, Frequent Urination, Painful Urination, Other. Each with Yes - No options.

GYNECOLOGY

- Abnormal Vaginal Bleeding, Vaginal Discharge, Is there any chance you could be pregnant?, Other. Each with Yes - No options.

MUSCULOSKELETAL

- Back pain, Joint Pain, Morning Stiffness, Raynaud's, Other. Each with Yes - No options.

NEUROLOGICAL

- Weakness on either side, Abnormal skin sensations or sensitivity, Headaches, Other. Each with Yes - No options.

INTEGUMENTARY

- Breast Discharge, Breast Lump, Breast Pain, Itching, Rash, Other. Each with Yes - No options.

PSYCHIATRIC

- Anxiety Disorder, Depression, Panic Attack, Sleep Disorder, Other. Each with Yes - No options.

ENDOCRINE

- Change In Hair Pattern, Dry Skin, Heat/Cold Intolerance, Other. Each with Yes - No options.

HEMATOLOGIC / LYMPHATIC

- Anemia, Bleeding / Bruising Tendency, Enlarged Lymph Nodes, Other. Each with Yes - No options.

ALLERGIC / IMMUNOLOGIC

- Chronic Nasal Congestion, Chronic Runny Nose, Frequent Sneezing, Watery Itchy Eyes, Other. Each with Yes - No options.

**IV. GENERAL MEDICAL HISTORY**

Arthritis Yes - No Diabetes Yes - No
Collagen Vascular Disease Yes - No High Blood Pressure Yes - No Heart Murmur Yes - No
Dialysis Yes - No Congestive Heart Failure Yes - No Mitral Valve Prolapse Yes - No
Kidney Disease Yes - No Heart Disease Yes - No Lung Disease Yes - No
Heart Attack Yes - No Heart Valve Replacement/Disease Yes - No Sleep Apnea Yes - No
If yes, give date \_\_\_\_\_ Heart Stents Yes - No C-PAP Machine Yes - No
If yes, give date \_\_\_\_\_ Heavy Snoring Yes - No

**GI PAST MEDICAL HISTORY**

**HAVE YOU EVER HAD A COLONOSCOPY? YES - NO**

Colon Polyps Yes - No Ulcer Disease Yes - No Liver Disease Yes - No
Colon Cancer Yes - No Irritable Bowel Syndrome Yes - No Pancreatitis Yes - No
GI Bleeding Yes - No Inflammatory Bowel Disease - Reflux (GERD) Yes - No
Other \_\_\_\_\_ Ulcerative Colitis - Crohn's Yes - No

**PAST SURGICAL HISTORY**

Please list all operations you have had:

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

Do you have sleep apnea? \_\_\_\_\_ Do you use a C-PAP machine? \_\_\_\_\_ **\*\*Please bring your machine with you for your procedure**

Have you ever experienced an adverse reaction (low blood pressure/heart rate, difficulty breathing, etc.) to intravenous sedations or anesthesia? Yes or No

If yes, for what operation/procedure \_\_\_\_\_ Date of procedure \_\_\_\_\_

Blood Transfusion? Yes or No When? \_\_\_\_\_

Have you ever donated blood/plasma/platelets in the past? Yes or No If yes, year of last donation \_\_\_\_\_

Have you ever been refused as a blood donor in the past? Yes or No If yes, why? \_\_\_\_\_

Radiation? Yes or No When? \_\_\_\_\_ Are you allergic to Lidocaine? Yes or No

Drug Allergies? Yes or No Are you allergic to eggs? Yes or No Are you allergic to soy? Yes or No

Please List: Are you allergic to latex? Yes or No

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

Are you currently taking prescription or over the counter medication? Yes or No

List all medicines you are taking (prescription and non-prescription) Please list all pain medicine, sleeping pills or nerve pills you are taking even if you only take them occasionally.

Table with 9 columns: Medicine, Dosage, Times/day, Medicine, Dosage, Times/day, Medicine, Dosage, Times/day

Do you use alcohol Yes or No Amount \_\_\_\_\_

Do you use tobacco Yes or No Packs per day \_\_\_\_\_

Do you use drugs Yes or No Type \_\_\_\_\_

Table with 3 columns: Who, Type (if known)