PATIENT REGISTRATION

Patient's Name _____ Date _____

Street Address_____ City _____ State & Zip _____

Home Phone (____) _____ Sex _____ Age _____ Date of Birth _____

Cell Phone (____)_____ Email Address _____ Race _____

Primary Language _____Employer _____ Occupation _____

Work Phone (____) _____ May we contact you at work? Y N

Referring Physician _____

Family Physician _____

Spouse's Name _____ Martial Status M S D W

Spouse's Occupation _____ Spouse's Birthday _____

FOR COMMERCIAL INSURANCES: I hereby authorize the insurance company(ies) listed to pay directly to The Center for GI Health for services furnished to me; otherwise, payable to me under terms of my insurance. I hereby authorize photocopies of this authorization to be considered valid and effective as the original.

Patients Signature _____ Date _____

LIFETIME MEDICARE AUTHORIZATION: I authorize any holder of medical or other information about me to release to the Social Security Administration & Health Care Financing Administration or its intermediaries or Carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original & request payment of authorized Medicare benefits to be made to Drs. Kucer, Markos, and Lukaszewski (The Center for GI Health). Regulations pertaining to Medicare assignment of benefits apply.

Patients Signature _____ Date _____

MEDIGAP: I request that payment of authorized Medigap benefits be made to either me or on my behalf to Drs. Kucer, Markos, and Lukaszewski (The Center for GI Health) for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to _____ any information needed to determine these benefits payable for related services.

Patients Signature _____ Date _____

Patient Name _____
Patient DOB _____
Date_____

Medical History

Please check if you have a **personal** or **family** history of the following:

	PERSONAL	FAMILY *List family member*
Abnormal Liver Tests	☐	☐ _____
Anal Fissure	☐	☐ _____
Anemia	☐	☐ _____
Arrhythmia	☐	☐ _____
Arthritis	☐	☐ _____
Asthma	☐	☐ _____
Atrial Fibrillation	☐	☐ _____
Blood Clots	☐	☐ _____
Colon Cancer	☐	☐ _____
Colon Polyps	☐	☐ _____
Crohn's Disease	☐	☐ _____
Depression	☐	☐ _____
Diabetes	☐	☐ _____
Diverticulitis	☐	☐ _____
Emphysema	☐	☐ _____
Gall Stones	☐	☐ _____
Gallbladder Disease	☐	☐ _____
Gastro Esophageal Reflux	☐	☐ _____
Glaucoma	☐	☐ _____
Heart Disease	☐	☐ _____
Heart Valve	☐	☐ _____
Hemorrhoids	☐	☐ _____
Hepatitis	☐	☐ _____
Jaundice	☐	☐ _____
High Blood Pressure	☐	☐ _____
Irritable Bowel Syndrome	☐	☐ _____
Kidney Disease	☐	☐ _____
Liver Disease	☐	☐ _____
Pacemaker	☐	☐ _____
Pancreatitis	☐	☐ _____
Seizures	☐	☐ _____
Sleep Apnea	☐	☐ _____
Stroke	☐	☐ _____
Thyroid Disease	☐	☐ _____
Ulcer	☐	☐ _____
Ulcerative Colitis	☐	☐ _____

Do you have any of the following symptoms?

	Yes	No
Abdominal Pain	☐	☐
Poor Appetite	☐	☐
Bloating/Belching	☐	☐
Difficulty Swallowing	☐	☐
Heartburn	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Regurgitation	☐	☐
Change in Bowel Habits	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Black, Tarry Stools	☐	☐
Rectal Bleeding	☐	☐
Recent Weight Change	☐	☐
Bleeding/Bruising	☐	☐
Fatigue	☐	☐
Fever	☐	☐
Blurred or Double Vision	☐	☐
Hearing Loss	☐	☐
Ear Ringing	☐	☐
Mouth Sores	☐	☐
Nose Bleeds	☐	☐
Chest Pain	☐	☐
Swelling of Ankles	☐	☐
Cough	☐	☐
Wheezing	☐	☐
Shortness of Breath	☐	☐
Joint Pain	☐	☐
Rash/Itching	☐	☐
Headaches	☐	☐
Memory Loss	☐	☐
Confusion	☐	☐
Feeling of Depression	☐	☐
Feeling of Anxiety	☐	☐
Blood in Urine	☐	☐

Patient Name _____
Patient DOB _____
Date_____

Other Personal Medical History _____

Other Family Medical History _____

List any surgeries you have had and the year of the surgery _____

_____

During any surgical procedure, have you been told you have difficult intubation? _____

Have you been diagnosed with Cancer? If so, please list site and when you were diagnosed _____

_____

Have you ever had an Upper Endoscopy? If so, what year? _____

Have you ever had a colonoscopy? If so, what year?_____

Have you ever had a flexible sigmoidoscopy? If so, what year? _____

Do you Have tattoos? _____ Have you ever been given a blood transfusion? _____

What is your daily caffeine intake? _____ Do you drink alcohol? _____

Do you smoke? _____ If no, have you ever? _____ Do you use IV/Street Drugs? _____

Signature _____ Date _____

THE BOXES BELOW ARE FOR OFFICE USE ONLY

Are there any changes to your medical history since your past visit? Y N

If so, what are they? _____

Signature _____ Date _____

Are there any changes to your medical history since your past visit? Y N

If so, what are they? _____

Signature _____ Date _____

Are there any changes to your medical history since your past visit? Y N

If so, what are they? _____

Signature _____ Date _____

Patient Name _____
Patient DOB _____
Date_____

Medication List

Pharmacy Name & Number _____ _____

Pharmacy Address _____

Allergies: _____ Please check here if none _____

Are you taking any blood thinners? (Examples: Coumadin, Warfarin, Plavix, Pradaxa, Xarelto, Brilinta, Effient, Aspirin) YES _____If Yes, please specify below NO _____

Blood Thinners _____

If you do not take any medications, please check here _____

Please list any prescribed and over the counter vitamins or supplements you are currently taking below:

MEDICATIONS	DOSAGE (MG)	HOW OFTEN TAKEN & WHEN