Dear	
You have been referred to our office for colorectal cand recommended for patients without GI symptoms. An off patients with recent or chronic GI complaints. Enclosed sent back to our office located at Five Irongate Center, procedure.	fice evaluation may be more appropriate for those I is a Patient Information form that must be filled out and
Our office will make every effort to verify your insurincreasing number of patients with high deductible due five days prior to your appointment. Payment strongate Center, Glens Falls, New York. If our office timeframe, your procedure will need to be rescheduted.	plans, all deductibles, copays and coinsurance are should be mailed or brought to our office at Five e does not receive payment <u>within the above</u>
We perform this procedure at Glens Falls Hospital, Sar located at Five Irongate Center in Glens Falls.	ratoga Surgery Center, and Northern GI Endoscopy
Once the paperwork has been received, a medical assiprocedure and optional educational planning session. when we call to enter the dates in the space below.	Please be prepared to have this form available
The optional educational session will give you an overver procedure. A nurse will be available to answer any que www.giassociatespc.com for further information in the session will give you an overver procedure.	estions. You can also visit our website at
	n full prior to scheduling future appointments. If
We thank you for your cooperation in advance. If you he call our office at 793-5034.	nave any questions regarding these instructions, please
Sincerely, Gastroenterology Associates Date for Education Session	at GI Associates 5 Irongate Center Glens Falls, NY
Date of your procedure	
Place of your procedure	

CONFIDENTIAL PATIENT INFORMATION for SCREENING COLONOSCOPY

Name	Date of birth				
Address_			Age_		
AddressCity	State	Zip_			
Telephone (Home)	(Work)	(Cell phone	: #)		
E-mail Black_	Marital S	Status S M W D	Gender	M F	
*Race: Caucasian Black_	Hispanic	_ Asian Other_			
*Ethnicity: Latino/Hispanic		-			
*Language: English Othe					
Patient's Social Security Number	er				
Primary Physician	Refe	rring Physician			
Other doctors involved in your o	care				
Other doctors involved in your of In Case of Emergency, Contact:		Phone #			
Employer's Name		Occupation			
Employer's Address		-			
*These questions are required Affordable Care Act. INSURANCE INFORMATIO	•	Government, related	i to nealth	icare reform a	ind tr
Primary Insurance					
Claim Address					
Policy Holder's Name	Pc				
Subscriber's ID#	Gr	oup#			
Secondary Insurance					
Claim Address					
Policy Holder's Name	Pc	olicy Holder's Date o	f Birth		
Subscriber ID#					
					7
Patients failing to cancel their color administrative fee of \$100. This fee must cancel or reschedule the example of the significant delays in reschedule to sickness or other health issues in	ee must be paid in fu mination, please call uling and if there are	ll prior to scheduling fu 793-5034 at the earliest e any questions regardi	iture appoin possible tir ng the need	ntments. If you ne. There are to cancel due	

CONTINUED ON OTHER SIDE→

hours and weekends).

We need to know if you have a fami (ie. mother, father sister, brother). F					
diagnosed.	icase list who had	a the problem and at	what age they were		
Family History of Colon Cancer? N	o Vec I	fves whom	Age diagnosed		
Family History of Colon Polyne? N	0 165 1	f ves. whom	Age diagnosed		
Family History of Colon Polyps? N	0 1 cs 1	f yes, who performed	Pr data		
Any Past Calamasany?	0 1es 1	Yes If yes, who performed & date Yes If yes, who performed & date			
Any Past Colonoscopy?	o Yes I	i yes, wno periormed	& date		
Have you ever been tested for slee If yes, do you have a diagnosis of s					
Height Weight					
Are you on any medications? Yes *Please list your prescribed medications					
MEDICATION	STRENGTH				
ALLERGIES:					
Medication Allergies:					
Latex Allergy: No Yes					
Other Allergies					
Are you having any new/recent bow No Yes If yes, explain			_		
Signature of Patient		Date			
Office use only	_				
Date form received in office					
Date of Colonoscopy	_ Refusal by pati	ient for Ed. Seminar	Yes No		