Dear _____:

You have an appointment in our _____office
on_____at_____ with_____.

Patients failing to cancel their appointments at least 24 hours in advance will be charged a $50.00 administrative fee. This fee must be paid in full prior to scheduling any future appointments.

In order to make your evaluation as complete as possible, we need the following:

1. Please bring your **insurance card** and **drivers license** with you on the day of your appointment. If your insurance requires a copay, this is due on the day of your appointment. This copay can be paid by cash, check, or credit card. **There will be a $25 billing/administrative fee for all copays that are not paid on the day of your appointment.**

2. If your insurance requires a **referral** please contact your primary care physician to make sure they have completed this. We will be happy to submit any claims to your insurance carrier but necessary referrals/authorization need to be obtained by you prior to your visit. We participate with most insurance plans but please contact your insurance company to verify we participate with your plan.

3. **Copies of medical records,** including labs, x-ray reports, and progress notes pertinent to your visit, from the physician who referred you to us. **We frequently do not receive records from referring physician and this may delay definitive medical opinion at the time of your visit due to delays in mailing, faxing, etcetera.** Please contact your referring physician to make sure they have sent records to our office.

4. Our practice utilizes an electronic medical record. In order to have your most up to date health information please complete the enclosed form and mail back to our office at least one week prior to your visit. This information will be scanned into our health information system prior to your visit and will expedite your evaluation.

The above information is integral to your evaluation, and without it your appointment may need to be rescheduled. We would like you to **arrive twenty (20) minutes** before your scheduled appointment time in order to complete preparations for your visit.

We thank you for your cooperation in advance. If you have any questions regarding these instructions, please call our office at 793-5034.

PATIENT INFORMATION: Date_____

Name_____Date of birth_____
Address_____Age_____
City_____State_____Zip_____
Telephone (Home)_____(Work)_____(Cell phone #)_____
E-mail _____Marital Status S M W D Gender M F
***Race:** Caucasian____ Black____ Hispanic____ Asian____ Other____
***Ethnicity:** Latino/Hispanic____ Other____
***Language:** English____ Other____
Patient's Social Security Number_____
Primary Physician_____Referring Physician_____
Other doctors involved in your care_____
In Case of Emergency, Contact:_____Phone #_____
Employer's Name_____Occupation_____
Employer's Address_____
Name of pharmacy you use: _____
Address of pharmacy: _____
***These questions are required by the Federal Government, related to healthcare reform and the Affordable Care Act.**

INSURANCE INFORMATION
Primary Insurance_____
Claim Address_____
Policy Holder's Name_____Policy Holder's Date of Birth_____
Subscriber's ID#_____Group#_____

Secondary Insurance_____
Claim Address_____
Policy Holder's Name_____ Policy Holder's Date of Birth_____
Subscriber ID#_____Group#_____

I hereby assign all medical and surgical benefits including Medicare, Private Insurance and other plans to Gastroenterology Associates of Northern New York, PC. I give authorization for record release to anyone necessary for billing or the continuation of my care for diagnosis and treatment.
Patient Signature_____**Date**_____

I hereby give permission to leave a message on my voicemail concerning my personal health information. I further understand that this permission to communicate my personal health information will be in effect until I request, in writing, to have this option terminated.
Patient Signature_____**Date**_____

Five Irongate Center, Glens Falls, NY 12801
CONFIDENTIAL HEALTH HISTORY

Welcome to our practice. In order to help provide the best possible gastrointestinal consultation, please complete this form prior to your upcoming visit.

Patient Name_____**Birthdate**_____**Date**_____

Referring Physician_____**Age**_____

Other Physicians involved in your care_____

Describe your main GI problem:_____

_____

Past Medical History
Have you ever had the following: (circle "no" or "yes", leave blank if uncertain)

AIDS or HIV….. no yes
Anemia…….. no yes
Arthritis……. no yes
Asthma……... no yes
Bleeding Tendency…… no yes
Blood Transfusion… no yes
Cancer no yes
Celiac Disease (Sprue) no yes
Colon Cancer… no yes
Colon Polyps…... no yes
Crohn's Disease.. no yes
Diabetes……... no yes
Diverticulosis/Diverticulitis no yes
Emotional illness…… no yes
Esophageal Reflux……. no yes
Gallstones…… no yes
Glaucoma…… no yes
Heart Disease no yes
Heart Murmur no yes
Heart Valve Replacement no yes
Hemorrhoids…….. no yes
Hepatitis……. no yes
Hernia…… no yes
High Blood Pressure…… no yes
IBS (Irritable Bowel Syndrome)…… no yes
Kidney Disease……. no yes
Liver Disease…….. no yes
Migraines…… no yes
Pancreatic Disorder… no yes
Seizure Disorder..…… no yes
Sleep Apnea…..…….. no yes
Thyroid Disease no yes
Turberculosis no yes
Ulcer……. no yes
Ulcerative Colitis…… no yes

Any other health problems_____

_____

Previous Surgeries/Serious Illnesses Requiring Hospitalization	**When?**	**Hospital/City/State**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous GI Evaluation (eg. colonoscopy, endoscopy, CT scan, etc.) No____ Yes____
(If yes, please list specific exams performed, the findings, and the date of the exam)

_____

_____

_____

_____

FAMILY HISTORY

[] Colon Cancer/relative: _____ Age at Diagnosis_____
[] Colon polyps/relative: _____ Age at Diagnosis_____
[] Liver Disease/relative:_____ [] Ulcerative colitis/Crohn's disease/relative:_____
[] Other malignancies – stomach, breast, ovary. If so, who was affected?_____

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____

Social History:

Use of Alcohol: No____ Yes ____ How often & qty._____ Marital Status S M W D
*Use of Tobacco: Never _____ Previously, but quit:_____ Current packs/day:_____
Use of drugs: Never _____ Type/Frequency:_____ Occupation_____

***Allergies:**
Medication Allergies:_____
Are you allergic to LATEX? Yes _____ No _____
Other Allergies:_____

Are you on any medications? Yes _____ No _____ If yes, please detail below

***Please list your prescribed medications and over the counter drugs including vitamins and supplements.**

MEDICATION	STRENGTH	FREQUENCY TAKEN

***These questions are required by the Federal Government, related to healthcare reform and the Affordable Care Act.**

Review of Systems: Please indicate any personal history below:

Constitutional Symptoms

Good General Health Lately no yes
Recent weight gain no yes
Recent Weight loss no yes
Fatigue no yes

Eyes

Eye disease or injury no yes
Cataracts no yes
Blurred or double vision no yes

Ears/Nose/Mouth/Throat

Hearing loss or ringing no yes
Chronic sinus problems no yes
Nose Bleeds no yes
Mouth Sores no yes
Swollen glands in neck no yes
Hoarseness no yes

Cardiovascular

Chest pain or angina pectoris no yes
Palpitations no yes
Shortness of breath no yes
Swelling of feet, ankles no yes

Respiratory

Chronic cough no yes
Spitting up blood no yes
Wheezing no yes
Use oxygen at home no yes
Sleep Apnea no yes
CPAP or BiCAP at home no yes

Gastrointestinal

Nausea no yes
Vomiting no yes
Change in bowel movements no yes
Black tarry stools no yes
Frequent diarrhea no yes
Constipation no yes
Rectal Bleeding no yes
Abdominal Pain no yes
Loss of appetite no yes
Heartburn no yes
Swallowing difficulties no yes
Bloating no yes
Dairy product intolerance no yes
Fatty food intolerance no yes

Genitourinary

Frequent urination no yes
Burning or painful urination no yes
Blood/air in urine no yes
Incontinence or dribbling no yes
Kidney stones no yes
Are you pregnant now no yes
Heavy Periods no yes

Musculoskeletal

Joint Pain no yes
Stiffness or swelling no yes
Muscle Cramps, weakness no yes
Back Pain no yes
Cold extremities no yes
Difficulty in walking no yes

Neurologic

Headaches no yes
Tremors no yes
Paralysis no yes
Head injury no yes
Lightheaded or dizzy no yes
Convulsions or seizures no yes

Psychiatric

Memory loss or confusion no yes
Nervousness/anxiety no yes
Depression no yes
Insomnia no yes

Endocrine

Thyroid Problems no yes
Heat or cold intolerance no yes
Skin becoming dryer no yes

Hematologic/Lymphatic

Bleeding or bruising tendency no yes
Phlebitis no yes

Integumentary (skin)

Rash or itching no yes
Jaundice no yes
Tattoos no yes
Change in hair or nails no yes

Other

_____
_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status.

_____ _____

Signature of Patient, Parent, or Guardian Date Signature of Physician Date

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