

NEW/RETURN PATIENT INFORMATION

DATE: _____

PATIENT LAST NAME: _____ FIRST: _____ MI: _____

DATE OF BIRTH: _____ MARITAL STATUS: _____ SEX: _____

RACE: _____ ETHNICITY: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE: HOME: _____ WORK: _____ CELL: _____

BEST METHOD TO CONTACT YOU – CELL – WORK – HOME – TEXT – OTHER: _____

HOW DO YOU WANT TO RECEIVE YOUR APPOINTMENT REMINDER? TEXT OR CALL

E-MAIL ADDRESS: _____

OCCUPATION: _____ EMPLOYER: _____

SPOUSE NAME: _____ DOB: _____

REFERRED BY: _____

PRIMARY CARE DOCTOR: _____ PHONE: _____ FAX: _____

EMERGENCY CONTACT PERSON: _____ RELATIONSHIP: _____

PHONE: HOME: _____ WORK: _____ CELL: _____

Main Reason for Today's Visit: _____

Current Complaints: (Check any of the following that apply to you)

Difficulty swallowing	___	Painful swallowing	___	Changes in weight	___
Abdominal pain	___	Blood in stool	___	Changes in appetite	___
Constipation	___	Diarrhea	___	Mucous in stool	___
Vomiting	___	Nausea	___	Heartburn	___
Regurgitation	___	Belching	___	Laxative use	___
Fever	___	Bloating	___	Hepatitis C	___
Maroon colored stool	___	Eating disorder	___	Liver enzyme abnormalities	___

Other GI Complaints: _____

Please check the following if they apply to you in the past three months:

	Y	N		Y	N
General:			Musculoskeletal:		
Anorexia	___	___	Back Pain	___	___
Fatigue	___	___	Joint Pain	___	___
Fever/Chills	___	___	Neurological:		
Weight Loss	___	___	Dizziness	___	___
Skin:			Headaches	___	___
Pruritis	___	___	Seizures	___	___
Rash	___	___	Psychiatric:		
HEENT:			Anxiety	___	___
Acute Vision Changes	___	___	Changes in Sleep	___	___
Earache	___	___	Depression	___	___
Sore Throat	___	___	Endocrine:		
Neck:			Appetite Changes	___	___
Mass	___	___	Thyroid Changes	___	___
Swollen Glands	___	___	Any Other Symptoms:	___	___
Respiratory:			_____		
Asthma	___	___			
Breathing Problems	___	___			
Bronchitis	___	___			
Cough	___	___			
Dyspnea	___	___			
Cardiovascular:					
Chest Pain	___	___			
Irregular Heartbeat	___	___			
Pacemaker	___	___			

HISTORY:

Allergies:

Do you have any drug allergies? Yes No

If yes, to what medications and what is the reaction: _____

Do you have allergies to Iodine? Yes No

Do you have allergies to Latex? Yes No

Medications:

Are you taking any medications? Yes No

Please list them along with the dosage and frequency: _____

PHARMACY NAME, City, and Phone Number: _____

Do you take blood thinners (Warfarin, Plavix, or Coumadin, etc.)? Yes No

Do you take Aspirin, Ibuprofen, or similar anti-inflammatory medications on a regular basis? Yes No

If yes to the above two questions, when was your last dose? _____

Have you ever been told that you need antibiotics before any procedure? Yes No

If YES, please notify your physician before your scheduled procedure date

Have you ever had an adverse reaction to Demerol, Versed, pain medication or anesthesia? Yes No

Family:

Does anyone in **your family** have a history of:

	Y	N	Who (Maternal/Paternal)	Age at Onset
Breast Cancer	___	___	_____	
Colon Cancer	___	___	_____	_____
Colon Polyps	___	___	_____	
Endometrial, Uterine or Cervical Cancer	___	___	_____	
Esophageal Cancer	___	___	_____	
Stomach Cancer	___	___	_____	

Personal Past Medical:

Do you have a history of any of the following:

	Y	N		Y	N
Heart conditions	___	___	Kidney Disease	___	___
Heart disease	___	___	Diabetes	___	___
Heart surgery	___	___	Strokes	___	___
Lung or breathing problems	___	___	Glaucoma	___	___
Sleep Apnea/CPAP	___	___	Any Other History	___	___
Hypertension	___	___	Mammogram	___	___
Flu Shot?	___	___	Last Month/Year	_____	
Pneumonia Shot?	___	___	Last Month/Year	_____	
COVID Vaccine	___	___	Moderna/Pfizer/JJ	Month/Year	_____

Please list any prior surgeries – if none please write none: _____

Social:

Do you smoke cigarettes?	Never	Current	Former	How much?	_____
				How many years?	_____
Do you drink alcohol?	Yes	No		How much?	_____
				How many years?	_____
Do you consume caffeine?	Yes	No		How much?	_____
				What type? (Soda/Coffee)	_____
Do you use IV/recreational drugs?	Yes	No		Which Ones?	_____

Triangle Gastroenterology, P.L.L.C.

Advanced Directives

Do you have an Advanced Directive, Living Will or Healthcare Power of Attorney? Yes _____ No _____
If you answered "yes", please consider providing us with a copy for your chart.

If you do not have an advanced directive, living will or healthcare power of attorney and want one a very user friendly one is available from www.caringinfo.org. Simply click on the "Download Your State Specific Advance Directive" link and find your home state.

The North Carolina form is here: <http://www.caringinfo.org/files/public/ad/NorthCarolina.pdf>.

Compound Authorization for Release of Information

Name of Patient: _____ **Date of Birth** _____

Triangle Gastroenterology is authorized to release protected health information about the above patient or others in keeping with the patients' instructions.

Entity to Receive Information Check each person/entity that you approve to receive information.	Description of Information to be released. Check each that can be given to person/entity on the left in the same row.
<input type="checkbox"/> Voice Mail – what number(s) _____	<input type="checkbox"/> Results of lab/tests/x-rays <input type="checkbox"/> Appointment/Surgery information
<input type="checkbox"/> Give information to employer <input type="checkbox"/> Give information to school	<input type="checkbox"/> Appointment/absentee information
<input type="checkbox"/> Spouse: _____ <input type="checkbox"/> Other(s): _____ _____ _____	<input type="checkbox"/> Family billing information <input type="checkbox"/> Financial <input type="checkbox"/> Demographic information <input type="checkbox"/> Appointment/surgical information <input type="checkbox"/> Medical as follows: _____

Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification Triangle Gastroenterology.

I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed because of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____ Date _____

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation)

Payment: We gladly accept checks, cash and credit cards (Visa, MasterCard, Discover and American Express).

Returned Checks: If your check is returned for any reason, a \$30 return check fee will be assessed. You will be required to rectify any payments due before another appointment can be made.

Self Pay: As a courtesy to our self pay patients, we offer a discount off our regular fee schedule. In return, we expect **payment in full** at the time of your office visit. Elective surgical procedures require a 50% down payment on the day of the surgery, with the balance due within 15 days after the surgery.

Collection Policy: Unless payment arrangements have been made, our policy states that all “patient due” accounts (*once your insurance company has paid their portion of your claim, or from the time of service for self pay patients*) over 90 days old to be referred to a licensed debt collection agency (collections costs will be added to the balance). Furthermore, patients with an unpaid balance over 90 days may be discharged from the practice.

Permission to Release information: This document authorizes Triangle Gastroenterology, PLLC to release personal health information to my insurance company(s), and other health care professionals for treatment, payment and other healthcare options.

Assignment of Insurance Benefits: If we have a contract with your insurance company and accept assignment, or if Medicare or Medicaid provides your insurance, your signature below assigns insurance benefits to Triangle Gastroenterology, PLLC for services rendered.

Attestation: Your signature (or the signature of your guardian) and that of the responsible party acknowledges that you understand and accept the above information.

Patient Printed Name

Patient’s Signature

Date: _____

Responsible Party’s Printed Name

Responsible Party’s Signature

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

***** You may refuse to sign this acknowledgement*****

I, _____ have reviewed and/or received a copy of this office's
Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but
acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other – please specify: