MRN	

GASTROINTESTINAL DISEASES, INC.

PATIENT INFORMATION FORM

PATIENT INFORMATION *Must provide ID at each appointment*		
Last Name:	First Name:	M.I.
DOB:	SSN:	
Home #:	Cell #:	Work #:
Street Address:		Apt #/Suite #:
City:	State:	Zip:
Email Address:		
Current occupation:	Currently working: ☐ Y ☐ N If yes, hours per week:	

EMERGENCY CONTACT		
Last Name:	First Name:	Phone:
Relationship to patient:		

INSURANCE INFORMATION *Must provide physical insurance card at each appointment*		
Full name as it appears on **Primary** Insurance Card:		
Insurance Name:	Member Id:	Group #:
Medical Claims Billing Address:		
Full name as it appears on **Secondary** Insurance Card: *if different from primary*		
Insurance Name:	Member Id:	Group #:
Medical claims billing address:		
Any additional Insurance Information: *add here, if insurance is obtained through spouse/partner, please provide their full name, ssn and employer*		

PLEASE MAKE SURE TO FILL OUT BOTH SIDES IN THE ENTIRETY

PATIENT INFORMATION

Last Name:	First Name:	DOB:

PHYSICIAN INFORMATION

Referring Physician:	Phone #:
PCP:	Phone #:

PHARMACY INFORMATION

Preferred Pharmacy Location:

HIPAA & PHI AUTHORIZATION FORM

The authorization for release of PERSONAL HEALTH INFORMATION is valid for ***1 year*** from date of signature on this form. I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse). Gastrointestinal Diseases Inc. may disclose your information (PHI), for treatment, payment, and health care operations purposes with your consent.

Signature:	Date:

EXLUDE the following information from records released:

AUTHORIZATION TO DISCLOSE PHI *valid for 1 year*

Name of family member or personal representative:

PLEASE MAKE SURE TO FILL OUT BOTH SIDES IN THE ENTIRETY

Authorization: I hereby authorize PH Patel MD, AD Patel MD, and S. Thiruppathi MD, to treat me. I authorize the release of medical information to my insurance to my company and any other Physicians of Entity involved in my care. I assign benefits of any insurance filed by Gastrointestinal Diseases Inc. (for PH Patel MD, AD Patel MD and S. Thiruppathi MD) to Gastrointestinal Diseases Inc. I understand that I am responsible for all charges for such medical services rendered. This authorization is valid until I change it with written notice to Gastrointestinal Diseases Inc.

Patient Signature: ______________________________ Date: ___________________________

Parent or Guardian Signature (if applicable) ____

Relationship to Patient: _________________________ Date: ___________________________

1130 Talbotton Road, Columbus, GA, 31904
Phone: 706-641-6900 Fax: 706-327-0757

Patient Interview Form

Patient Information

First Name:____________ Last Name:____________

Date Of Birth:____________

Age:____________ Notes:____________

Email

Please check one as your preferred email for communications

- ◯ Personal:____________
- ◯ Work:____________

Race

Select one or more.

- ◯ White
- ◯ Black or African American
- ◯ Asian
- ◯ American Indian or Alaska Native
- ◯ Native Hawaiian or Other Pacific Islander
- ◯ Other Race
- ◯ Unknown
- ◯ Patient declines to specify
- ◯ Prohibited by state law

Ethnicity

- ◯ Hispanic or Latino
- ◯ Not Hispanic or Latino
- ◯ Patient declines to specify
- ◯ Prohibited by state law
- ◯ Unknown

Sex

- ◯ Male
- ◯ Female
- ◯ Other
- ◯ Unknown

Preferred Language

- ◯ English
- ◯ Patient declines to specify

Contact Preference

- ◯ Portal Message
- ◯ Patient declines to specify
- Other:____________

Allergies

- ◯ Patient has no known allergies
- ◯ Patient has no known drug allergies

Other

- ◯ Latex
- ◯ Shellfish
- ◯ Seafood
- ◯ Eggs
- ◯ Tylenol
- Other:____________

Antibiotics

- ◯ Cipro
- ◯ Flagyl
- ◯ Penicillins
- ◯ erythromycin
- ◯ Sulfa (Sulfonamide Antibiotics)
- Other:____________

Other Medications

- ◯ Demerol
- ◯ Codeine Sulfate
- ◯ Iodine And Iodide Containing Products
- ◯ Analgesic (aspirin/caffeine)

◯ morphine (bulk) Other: ____________

Current Medications

◯ None

Name	Dose	How taken?

Immunizations

◯ None

◯ Pneumonia When: ____________ ◯ Flu When: ____________

Past or Present Medical Conditions

◯ None

GI
- ◯ Gallstones
- ◯ Crohn's Disease
- ◯ Cirrhosis
- ◯ Gastric Ulcer
- ◯ IBS
- ◯ Autoimmune Hepatitis
- ◯ Colon polyps
- ◯ Hepatitis B
- ◯ GI Bleed
- ◯ Colitis
- ◯ Hepatitis C
- ◯ GERD

Other: ____________

Cardiac
- ◯ High blood pressure
- ◯ Congestive Heart Failure (CHF)
- ◯ Coronary Artery Diseases (CAD)
- ◯ Mitral Valve Prolapse (MVP)

Other: ____________

Cancer
- ◯ Breast Cancer
- ◯ Colon Cancer
- ◯ Esophageal Cancer
- ◯ Lung Cancer
- ◯ Prostate Cancer
- ◯ Ovarian Cancer

Other: ____________

Other
- ◯ Asthma
- ◯ Diabetes
- ◯ HIV
- ◯ Currently Pregnant
- ◯ Dementia
- ◯ Alzheimer's disease
- ◯ End-stage renal disease
- ◯ Wheelchair bound
- ◯ Dependence on supplemental oxygen
- ◯ History of falling

Other: ____________

Previous Procedures

◯ None

Other
- ◯ C-Section When: ____________
- ◯ Hysterectomy When: ____________
- ◯ Hemorrhoidectomy When: ____________
- ◯ Tubaligation When: ____________

GI Surgeries/Procedures
- ◯ Appendectomy When: ____________
- ◯ Colon Resection When: ____________
- ◯ Colonoscopy When: ____________
- ◯ EGD When: ____________
- ◯ ERCP When: ____________
- ◯ Gastric-By-Pass When: ____________

Other: ____________

Cardiac Surgeries/Procedures

- ( ) Angioplasty When: ________
- ( ) Cardiac Catherization When: ________
- ( ) Stents When: ________
- ( ) Coronary artery bypass surgery When: ________
- ( ) Valve Replacement When: ________
- ( ) Defibrillator placement. When: ________
- Other: ________

Social History

Occupation: ________ Number of Children: ________

Marital Status

- ( ) Single
- ( ) Married
- ( ) Divorced
- ( ) Separated
- ( ) Widowed
- ( ) Civil Union
- ( ) Unknown
- ( ) Other

Alcohol

- ( ) None

Type	Number
( ) Never	
( ) Rarely	
( ) Daily	
( ) More than 2 days/week	
( ) Less than 2 days/week	
( ) I quit using alcohol	
( ) Recovering alcoholic	

Tobacco

Smoking Status

- ( ) Current every day smoker
- ( ) Current some day smoker
- ( ) Former smoker
- ( ) Never smoker
- ( ) Smoker, current status unknown
- ( ) Light tobacco smoker
- ( ) Heavy tobacco smoker
- ( ) Unknown if ever smoked

Drug Use

- ( ) None

Type	Number
( ) I use illicit drugs	
( ) I quit using illicit drugs	
( ) Injection drug use	

Family Medical History

- ( ) No knowledge of family history

No family history of ( ) Colon cancer ( ) Polyps

Health Status	Mother	Father	Sister	Brother	Daughter	Son
Healthy	O	O	O	O	O	O
Diagnoses						
Colon cancer	O	O	O	O	O	O
Colon polyps	O	O	O	O	O	O
Crohns disease	O	O	O	O	O	O
Esophageal cancer	O	O	O	O	O	O

Gastric cancer ○ ○ ○ ○ ○ ○

Gastric polyps ○ ○ ○ ○ ○ ○

Liver cancer ○ ○ ○ ○ ○ ○

Pancreatic cancer ○ ○ ○ ○ ○ ○

Other: ○ ○ ○ ○ ○ ○

Review Of Systems

Cardiovascular

○ None

	Y	N
chest pain	○	○
irregular heart beat	○	○
orthopnea	○	○
palpitations	○	○
shortness of breath with exercise	○	○
syncope	○	○

Constitutional

○ None

	Y	N
fatigue	○	○
fever	○	○
loss of appetite	○	○
weight gain	○	○
weight loss	○	○

ENMT

○ None

	Y	N
difficulty swallowing	○	○
dizziness	○	○
sore throat	○	○

Endocrine

○ None

	Y	N
excessive thirst	○	○
hair loss	○	○
heat intolerance	○	○
hoarseness	○	○
mouth sores	○	○

Gastrointestinal

○ None

	Y	N
abdominal distention	○	○
abdominal pain	○	○
abdominal swelling	○	○
anal/rectal pain	○	○
black stools	○	○
change in bowel habits	○	○
constipation	○	○
diarrhea	○	○
trouble swollowing	○	○
gas	○	○
heartburn	○	○
incontinence	○	○
jaundice	○	○
nausea	○	○
pain with bowel movements	○	○
rectal bleeding	○	○
rectal urgency	○	○
vomiting	○	○

Genitourinary

○ None

	Y	N
dark urine	○	○
decrease in urine flow	○	○
dysuria	○	○
frequent urinary infections	○	○
frequent urination	○	○
hematuria	○	○
impotence	○	○
nocturia	○	○
urethral discharge or incontinence	○	○

Hematologic/Lymphatic

○ None

	Y	N
bleeding gums or palpable lymph nodes	○	○
easy bruising	○	○
prolonged bleeding	○	○

Integumentary

○ None

	Y	N
allergies	○	○
dryness	○	○
hives	○	○
itching	○	○
jaundice	○	○
lesions	○	○
rashes	○	○

Musculoskeletal

○ None

	Y	N
arthritis	○	○
back pain	○	○
joint pain	○	○
muscle weakness	○	○
stiffness	○	○

Neurological

○ None

	Y	N
dizziness	○	○
fainting	○	○
frequent headaches	○	○
migraine	○	○
numbness or tingling	○	○
seizures	○	○
tremors	○	○

Psychiatric

○ None

	Y	N
anxiety	○	○
depression	○	○
hallucinations	○	○
nervousness	○	○
panic attacks	○	○
paranoia	○	○

Respiratory

○ None

	Y	N
asthma	○	○
cough	○	○
coughing up blood/hemoptisis	○	○
excessive sputum	○	○
shortness of breath	○	○
wheezing	○	○

Pharmacy

Name Address Phone

Consent to Import Medication History

I consent to obtaining a history of my medications purchased at pharmacies.

- [ ] Yes
- [ ] No

Reviewed with

- [ ] Patient
- [ ] Parent
- [ ] Guardian
- [ ] Not Present

Signature

Signature | Date