

Date _____

Patient Information

Thank you for choosing our office! In order to serve you well, we need the following information. Please print. All your medical information will be kept confidential.

Patient Information

Name _____ Birthdate _____ SS# _____
 Address _____
 City _____ State _____ Zip _____
 Home Phone _____ Work Phone _____ Cell Phone _____
 Martial Status _____ Spouse's Name _____
 Employer _____
 Person to contact in an emergency _____ Phone _____
 Primary Care Doctor _____ Referring Doctor _____

Insurance Information

Primary Insurance

Insurance Company _____
 ID# _____ Group # _____
 Policy Holder (if other than patient) _____ Birthdate _____
 Relationship to patient _____ Employer of Policy Holder _____
 Address _____
 Work Phone _____ Cell _____ SS# _____

Secondary Insurance

Insurance Company _____
 ID# _____ Group # _____
 Policy Holder (if other than patient) _____ Birthdate _____
 Relationship to patient _____ Employer of Policy Holder _____
 Address _____
 Work Phone _____ Cell _____ SS# _____

Assignment of Benefits and Authorization for Release of Information

I authorize release of any information concerning my or my child's health care, advice and treatment provide for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits directly to my physician. I am financially responsible for non-covered expenses.

We are committed to providing you with the best possible care. As a service to you, we will file your insurance claim with necessary information in a timely fashion. Any balances after insurance pays will be billed to you for payment.

Please remember that your contract is between you and your insurance company to provide reimbursement for medical care. We cannot be responsible for unwarranted delays by your insurance company or HMO. If your coverage is not what you expect, please discuss it with insurance company or employer.

Most insurance policies will not cover the entire expense for your care. Please pay you co-pay at time of check out. In most cases, you will be required to make a deposit at the time you surgery is scheduled. For your convenience, we accept cash, checks, and most major credit cards.

Acknowledgement of Receipt of Privacy Notice

I understand that my physician or staff may share my / my child's medical information for treatment, billing, and healthcare business purposes. I acknowledge that I have been given information that describes how my / my child's medical information is used and shared.

X Signature of patient/parent _____ Date _____

This signature is valid from this date and continues until revoked.

New or Updated Patient Medical History

Name: _____ Date of Birth: _____ Your Primary M.D. _____

Date Form Filled Out: _____ Date of Appt: _____ Your Age: _____

Which Physician Sent You to Our Office For This Consultation (Office Visit)?

(Physician's first and last name)

Briefly, why are you seeing our physician today? _____

Have you recently seen another physician for this current illness? YES NO

ALLERGIES:

LIST ALL MEDICATIONS:

PLEASE INCLUDE ALL VITAMINS, HERBAL SUPPLEMENTS, AND OVER THE COUNTER MEDICINES

NAME

DOSE

REVIEW OF SYSTEMS

INDICATE BELOW ANY SYMPTOMS YOU ARE CURRENTLY HAVING:

| | | | | | |
|-----------------------------|-----|-----|------------------------------|-----|-----|
| 1. GENERAL: | YES | NO | 6. ALLERGIC: | YES | NO |
| A. Fatigue | ___ | ___ | A. (Circle) | | |
| B. Weight Loss | ___ | ___ | Itchy eyes, nose, | | |
| C. Fevers | ___ | ___ | ears, palate | | |
| D. Chills | ___ | ___ | B. Watery Eyes | ___ | ___ |
| E. Nausea | ___ | ___ | C. Scratchy Throat | ___ | ___ |
| F. Headaches | ___ | ___ | D. Sneezing Excessively | | |
| 2. SKIN: | | | 7. MOUTH: | | |
| A. Lesions | ___ | ___ | A. Lesions | ___ | ___ |
| 3. EYES: | | | B. Loss of Taste | ___ | ___ |
| A. Double Vision | ___ | ___ | 8. THROAT: | | |
| B. Blurred Vision | ___ | ___ | A. Pain | ___ | ___ |
| C. Loss of Vision | ___ | ___ | B. Hoarseness | ___ | ___ |
| 4. EARS: | | | C. Cough | ___ | ___ |
| A. Hearing Loss | ___ | ___ | D. Difficulty Swallowing | ___ | ___ |
| B. Family History | ___ | ___ | E. Indigestion, Heartburn | ___ | ___ |
| C. Exposure-Loud Noises | ___ | ___ | 9. NECK: | | |
| D. Drainage | ___ | ___ | A. Pain and/or Lumps | ___ | ___ |
| E. Pain | ___ | ___ | 10. HEART AND CIRCULATION: | | |
| F. Noise in Ears (Tinnitus) | ___ | ___ | A. Chest Pain | ___ | ___ |
| G. Dizziness | ___ | ___ | B. Irregular Heart Beat | ___ | ___ |
| 5. NOSE: | | | C. Leg Swelling | ___ | ___ |
| A. Pain | ___ | ___ | 11. LUNGS: | | |
| B. Discharge | ___ | ___ | A. Shortness of Breath | ___ | ___ |
| C. Post Nasal Drip | ___ | ___ | B. Congestion | ___ | ___ |
| D. Deformity | ___ | ___ | C. Wheezing | ___ | ___ |
| E. Congestion | ___ | ___ | D. Productive Cough | ___ | ___ |
| F. Decreased Smell | ___ | ___ | 12. NERVES: | | |
| G. Bleeding | ___ | ___ | A. Numbness | ___ | ___ |
| H. Snoring | ___ | ___ | B. Localized Weakness | ___ | ___ |
| | | | C. Paralysis | ___ | ___ |
| | | | 13. STOMACH AND INTESTINES | | |
| | | | A. Nausea and/or Vomiting | ___ | ___ |
| | | | B. Constipation | ___ | ___ |
| | | | C. Diarrhea | ___ | ___ |
| | | | D. Rectal Bleeding | ___ | ___ |
| | | | E. Bloating | ___ | ___ |
| | | | F. Abdominal Pain | ___ | ___ |
| | | | 14. BLOOD SYSTEM: | | |
| | | | A. Bleeding or Easy Bruising | ___ | ___ |

CONTINUED ON NEXT PAGE

Patient Name: _____

| <u>PAST HISTORY</u> | | | | | |
|---|-------|-----|------------------------------------|-----|-----|
| | YES | NO | | YES | NO |
| Problems with General Anesthesia | ___ | ___ | Previous Surgery | ___ | ___ |
| INDICATE BELOW ANY HISTORY OF DISEASES <u>YOU HAVE HAD</u> | | | | | |
| Medical Illnesses: | YES | NO | | YES | NO |
| Lung Disease | ___ | ___ | Hypertension (High Blood Pressure) | ___ | ___ |
| Asthma | ___ | ___ | Urinary Disease | ___ | ___ |
| Heart Disease | ___ | ___ | Pelvic Disease | ___ | ___ |
| Blood Vessel Disease | ___ | ___ | Prostate Disease | ___ | ___ |
| Glaucoma | ___ | ___ | Kidney Disease | ___ | ___ |
| Arthritis | ___ | ___ | Diabetes | ___ | ___ |
| Bleeding Tendency | ___ | ___ | Hepatitis | ___ | ___ |
| Seizures | ___ | ___ | | | |
| List any other health conditions | _____ | | | | |

| <u>FAMILY HISTORY</u> | | | | | |
|---|-------|-----|--------------------------|-----|-----|
| INDICATE BELOW THE DISEASE IN <u>YOUR PARENTS, BROTHERS OR SISTERS</u> | | | | | |
| | YES | NO | | YES | NO |
| Cancer | ___ | ___ | Hearing Loss | ___ | ___ |
| Heart Disease | ___ | ___ | Bleeding Abnormalities | ___ | ___ |
| Hypertension (High Blood Pressure) | ___ | ___ | Anesthesia Complications | ___ | ___ |
| Lung Disease | ___ | ___ | Allergies | ___ | ___ |
| List any other health conditions | _____ | | | | |

| <u>SOCIAL HISTORY</u> | | | | |
|---|-----|-----|--------------|----------|
| Current or Previous Occupation: _____ | | | | |
| | YES | NO | | |
| Are you pregnant? | ___ | ___ | | |
| Caffeine Use? | ___ | ___ | | |
| Alcohol Use? | ___ | ___ | Amount _____ | per week |
| Recreational Drug Use | ___ | ___ | | |
| Tobacco Use? | ___ | ___ | | |
| Year quit _____ If smoking, type of tobacco _____ # _____ of packs per day for # _____ years. | | | | |

The above information is correct.

Patient Signature: _____

Date: _____

I have reviewed both sides of this medical history form.

Physician Signature: _____

Date: _____

Authorization for Release of Information to Family and/or Friends

Name of Patient _____ Date of Birth _____

Center for Digestive Diseases and Cary Endoscopy Center, PC, is authorized to release protected health information about the above named patient to the entities named below.

Entity to Receive Information. Initial each that is subject to this authorization,

_____ Leave information on the voice mail

_____ Give information to spouse

_____ Release Financial Information

_____ Give information to the following person/s; _____

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 to Center for Digestive Diseases and Cary Endoscopy, PC. 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 as a result of this authorization may be subject to redisclosure 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.

This authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

_____ Date _____
Signature of Patient or Personal Representative

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

**CENTER FOR DIGESTIVE DISEASES
& CARY ENDOSCOPY CENTER
1120 SE CARY PARKWAY STE 204
CARY, NC 27511
PHONE (919) 854-0041
FAX (919) 854-0049**

**THIS IS VERY IMPORTANT! PATIENTS PLEASE MAKE SURE THAT YOU READ
AND UNDERSTAND BEFORE SIGNING!**

Dear Patient,

We would like to take this opportunity to acquaint you with our office and billing procedures. It is our goal to satisfy you and make the financial aspects of your health care as convenient as possible. Therefore, as a courtesy to you, we file most insurance.

We will need a photocopy of your insurance card in order to process your claim. Without your card you will be responsible for full payment at the time that services are rendered. If your plan requires an annual deductible, we will need you to bring an explanation of benefits statement/form from your insurance carrier that shows that the deductible has been met.

All patients who have insurance that requires an authorization (referral) are responsible for obtaining that authorization. When no authorization has been received prior to your appointment; you will be asked to either reschedule your appointment or be responsible for the full bill.

Co pay or coinsurance will be due at the time services are rendered. If you have a co pay or coinsurance you will be expected to pay it at every office visit. If you are scheduled for a procedure we will be responsible for obtaining authorization if it is needed. We will call your insurance company prior to your procedure to find out approximately what you will owe. We will inform you of what this amount is as soon as we can and **you will be expected to pay it on the day of your procedure.** If this amount includes a deductible and you believe that you have already met it, you will need to bring an explanation of benefits statement/form from your insurance carrier that shows that the deductible has been met.

We require that you notify us twenty-four (24) hours in advance prior to any office cancellations, or forty-eight (48) hours in advance for a procedure cancellation or there will be a \$25.00 charge applied to the patient for the missed appointment and a \$50.00 charge for a missed procedure. The Physicians do reserve the right to cancel an appointment or procedure due to a conflict in scheduling.

We thank you for the opportunity to serve you!

I have read, understand and accept the above billing and insurance procedures

Patients Name

Date

CENTER FOR DIGESTIVE DISEASES and CARY ENDOSCOPY CENTER, P.C.

Due to State of North Carolina Certification Guidelines, we are now required to report, ***Ethnic Origin and Race*** of all patients.

Patient Name: _____

Please Select the appropriate category:

Ethnic Origin:

_____ Hispanic

_____ Non Hispanic

_____ Declined

Race:

_____ American Indian/ Alaska Native

_____ Asian

_____ Black/ African American

_____ Hispanic

_____ Multiple Race/ Other

_____ Native American

_____ Native Hawaiian

_____ Other Pacific Island

_____ White

_____ Declined/ Unavailable