



Gastrointestinal Associates, P.A.

Patient Registration Information

- WILLIAM A. HARTONG, M.D.
- WILLIAM D. BUSER, M.D.
- JOHN A. THESING, M.D.
- JAMES A. MAVEC, M.D.
- JEFF L. YOUNG, M.D.
- DONNA M. GRAESSLE, D.O.
- RANDAL L. BROWN, M.D.
- J. CHRIS NICHOLS, M.D.
- CHRISTIAN C. MCELHINNEY, M.D.
- JOHN B. STURGEON, M.D.

Please **PRINT** and complete **ALL** sections below!
Please give to the doctor at your scheduled appointment.

Date: _____ Marital Status: Single Married
 Patient's Name: _____ Date of Birth: _____ Sex: M F
 Address: _____ Apt.# _____ Home Phone: _____
 City: _____ State: _____ Zip: _____ SSN: _____ Cell Phone: _____
 e-mail: _____
 Employer: _____ Work Phone: _____
 Address: _____ City: _____ St: _____ Zip: _____

EMERGENCY CONTACT (Friend or relative not living with you)

Name: _____ Sex: M F
 Address: _____ Apt.# _____ Home Phone: _____
 City: _____ State: _____ Zip: _____ Cell Phone: _____
 Employer: _____ Work Phone #: _____
 Address: _____ City: _____ St: _____ Zip: _____

RESPONSIBLE PARTY: Self Other _____

Insurance information:

Primary Insurance:

Name of Insurance Co: _____
 Address: _____
 City & St: _____ Zip: _____
 Policy/ID Number: _____ Group: _____
 Medicare ID _____
 Subscriber's Name: _____ DOB _____
 Is this insurance thru Employer _____
 Group Name: _____

Secondary Insurance:

Name of Insurance Co: _____
 Address: _____
 City & St: _____ Zip: _____
 Policy/ID Number: _____ Group: _____
 Medicare ID _____
 Subscriber's Name: _____ DOB _____
 Is this insurance thru Employer _____
 Group Name: _____

Do you have other Insurance: _____

Patient is seeing Dr. due to: Accident Illness Injury

Have you or any member of your family been treated by our physicians before: YES N

Drug Allergies, if any: _____ Reaction: _____
 Primary Physician: _____ Phone: _____ Fax: _____
 Pharmacy: _____ Address: _____ Phone: _____

Authorization of Treatment

While I am here I permit the employees, the healthcare provider, and all other person caring for me to treat me in ways they judge are beneficial to me. I understand the attending healthcare provider will explain to me the nature of my condition and his/her recommended treatment and any associated risk involved. I further understand that this care may include diagnostic testing, examinations, medical and/or surgical treatment and no guarantees have been made to me about the outcome of this care.

Medicare / Medicaid Lifetime Consent

I certify that the information given me in applying under Title XVII of the Social Security Act is correct. I authorize any holder of medical and/or other information about me to release it to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare Claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to the healthcare provider or organization to submit a claim to Medicare for payment to me.

All Other Insurance

Authorization is hereby granted to Gastrointestinal Associates, PA. to release medical records and such information as may be requested for the completion of my claims to my insurance company. I further authorize payment for medical benefits to be made directly to Gastrointestinal Associates, PA.

I understand that I am personally responsible for all Services provided by Gastrointestinal Associates, PA.

Signature _____

Date _____

Signature _____

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Signature _____

Date _____



HISTORY & PHYSICAL

PLEASE FILL OUT AND BRING WITH YOU TO YOUR APPOINTMENT

Patient Identification

DATE: ___ / ___ / ___

Name: _____ (Last) _____ (First) _____ (Middle)
Age: _____ Date of Birth: ___ / ___ / ___ Sex: ___ Male ___ Female
Race: _____ Social Security #: - - - Primary Doctor: _____

Chief Complaint

(Stated as simply as possible. Include type of complaint: mass, pain*, abnormal test, fever, weight change, etc. Include duration of symptoms.)

* If the chief complaint is **pain**, it is best described as:

- | | | | |
|--------------|------------------|----------------|-----------------|
| ___ Severe | ___ Moderate | ___ Mild | ___ Needle-like |
| ___ Periodic | ___ Intermittent | ___ Burning | ___ Superficial |
| ___ Stabbing | ___ Cramping | ___ Deep | ___ Sudden |
| ___ Sharp | ___ Dull | ___ Gnawing | ___ Other _____ |
| ___ Gradual | ___ Shifting | ___ Continuous | _____ |

History of the Present Illness

Date of onset: ___ / ___ / ___

Initial Symptoms: _____

Progression of Symptoms: _____

What initiates symptoms? _____

What relieves symptoms? _____

Associated symptoms: _____

Character of symptoms recently: ___ More Frequent ___ More Intense ___ Continuous
___ Less Frequent ___ Less Intense ___ Periodic

Past Medical History

Name: _____

(Check those conditions that apply.)

Previous Illnesses:

Anemia

- Iron Deficiency
- Vitamin B12 Deficiency
- Other

Blood Disease

- Leukemia
- Bleeding Disorder
- Blood Clots
- Phlebitis
- Clotted Veins
- Clotting Problems
- Other

Cancer

Type _____

Cardiovascular

- Heart Attack
- Heart Stents
- Murmur
- Hypertension
- High Cholesterol
- High Triglycerides
- Angina/Chest Pain
- Heart Valve
- Other

Communicable Diseases

- Rheumatic Fever
- Polio
- Parasites
- Dysentery
- Syphilis
- Gonorrhea
- Other

Endocrine

- Diabetes
- Thyroid
- Goiter
- Other

ENT

- Sinusitis
- Hay Fever
- Blurred Vision
- Cataracts
- Other

Misc

- Gout
- Arthritis
- Skin Problems
- Muscle Problems
- Hernia
- Other

Gastrointestinal

- Ulcer
- Gastritis
- Duodenitis
- Hiatal Hernia
- Gallstones
- Pancreatitis
- Colon Polyp
- Diverticulosis
- Diverticulitis
- Ulcerative Colitis
- Crohns
- Hemorrhoids
- Fissure/Abscess
- Irritable Bowel Syndrome
- Bowel Obstruction
- Other

Genitourinary

- Kidney Infection
- Kidney Stone(s)
- Bladder Trouble
- Prostate Growth
- Sexual Problems
- Gynecological Problems
- Other

Liver

- Jaundice
- Hepatitis
- Other

Neurology

- Epilepsy
- Multiple Sclerosis
- Stroke/TIA
- Paralysis
- Headaches
- Other

Psychological

- Mental Illness
- Nervousness
- Other

Pulmonary

- Emphysema
- Bronchitis
- Pneumonia
- Asthma
- TB
- Pleurisy
- Other

Vaccines

- Hepatitis A
- Hepatitis B
- Tetanus

Comments: (Explain anything marked &/or numbered above, if necessary.) _____

Hospitalizations: (Include all major illnesses, injuries, & operations.)

Date	Hospital	Diagnosis	Treatment	Physician
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Allergies:

Agent or Medication:	Reaction:
_____	_____
_____	_____
_____	_____
_____	_____

Current Medications:

Medication:	Dosage:	Frequency:	Duration of use:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Review of Systems

Name: _____

(Check those which have occurred recently.)

General

- Weight gain
- Weight loss
- Weakness
- Fatigue
- Fever
- Chills
- Night sweats
- Fainting

Skin

- Color changes
- Nail changes
- Hair changes
- Mole changes
- Rashes
- Itching
- Sores
- Dryness

Head

- Headaches
- Injuries
- Bumps/Lumps
- Glasses
- Contacts

Eyes

- Blurred vision
- Cataracts
- Glaucoma
- Redness/Itching
- Burning
- Swelling
- Pain
- Dryness
- Tearing

Ears

- Hard of hearing
- Deafness
- Ringing
- Discharge
- Earache
- Itching
- Loss of balance
- Dizziness
- Room spins

Nose

- Decreased smell
- Bleeding
- Pain
- Discharge
- Obstruction
- Post nasal drip
- Deviated septum
- "Rummy" nose
- Sinus congestion

Mouth

- Bleeding gums
- Sores
- Dental problem
- Pain
- Bad breath
- Loss of taste
- Dry mouth
- Ulcers
- Blisters

Throat

- Soreness
- "Bad" tonsils
- Hoarseness
- Pain
- Trouble swallowing
- Recurrent infections

Neck

- Enlargement
- Stiffness
- Soreness
- Lumps
- Masses

Breasts

- Discharge
- Lumps
- Pain
- Bleeding
- Nipple changes
- Skin changes
- Fullness

Lungs

- Cough
- Phlegm
- Blood in sputum
- Short of breath
- Wheezing
- Pain
- Congestion
- Inhalant exposure

Heart

- Murmur
- Palpitations
- Rapid heart beat
- Swollen legs
- Cold extremities
- Chest pain
- Chest pressure
- Varicose veins
- Blood clots
- Blue extremities

Blood

- Anemia
- Low Blood Iron
- Easy bruising
- Easy bleeding
- Swollen nodes
- Painful nodes
- Sugar in blood
- Red spots

Gastrointestinal

- Abdominal pain
- Nausea
- Vomiting
- Bloating
- Belching
- Heartburn
- Indigestion
- Irregular bowel habits
- Constipation

Gastrointestinal

- Diarrhea
- Gas
- Hemorrhoids
- Hernia
- Poor appetite
- Food intolerance
- Bloody stools
- Black stools

Genitourinary

- Urgency
- Incontinence
- Straining
- Back pain
- Frequent voiding
- Stones
- Burning
- Bed wetting
- Bloody urine

Genitourinary

- Small stream
- Discharge
- Sores
- Impotence
- Dribbling
- Cloudy urine

Gynecological

- Spotting
- Menstrual cramps
- Discharge
- Itching
- Painful intercourse
- Irregular periods
- Hot flashes

Gynecological

- Contraception
- Age at 1st period
- Age at menopause
- Duration of cycle
- Duration of flow
- # of pregnancies
- # of births
- # of miscarriages
- # of abortions

Gynecological

- Menstrual flow
(Heavy, Mod, Light)
- / / LMP
- Hysterectomy
- Other _____

Musculoskeletal

- Muscle pain
- Muscle weakness
- Muscle cramps
- Joint pain/swelling
- Back pain
- Other

Neurological

- Seizures
- Dizziness
- Sensory loss
- Paralysis
- Memory loss
- Numbness

Psychiatric

- Anxiety
- Depression
- Irritability
- Hallucinations
- Drug Dependency
- Suicidal tendency

Endocrine

- Heat intolerance
- Cold intolerance
- Voice changes
- Extreme thirst
- Breast changes

Name: _____

Family History

Relationship	Age (Living)	Age (At Death)	State of Health / Illnesses / Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings _____	_____	_____	_____
_____	_____	_____	_____
Paternal Grandfather	_____	_____	_____
Paternal Grandmother	_____	_____	_____
Maternal Grandfather	_____	_____	_____
Maternal Grandmother	_____	_____	_____
Other _____	_____	_____	_____
_____	_____	_____	_____

Social History

Current weight _____ **Usual weight:** _____ **Maximum weight:** _____ **Minimum weight:** _____
Marital status: _____ Single _____ Married _____ Divorced
Mental work: _____ Strenuous _____ Moderate _____ Light _____ Hours/Day
Physical work: _____ Heavy _____ Moderate _____ Light _____ Hours/Day
Exercise: _____ Heavy _____ Moderate _____ Light _____ Hours/Week
 Type of Exercise: _____
Tobacco use: _____ Packs/Day _____ Packs/Day _____ No. of years _____ Quit
 (Currently) (Previously) (mo/year)
Alcohol use: _____ Amount per Week
Caffeine use: _____ Cups per day (Coffee, tea, cola) .
Drugs: (List the number of doses per week.)
 _____ Vitamins _____ Antacids _____ Pain Pills _____ Nerve Pills _____ Potassium
 _____ Laxatives _____ Diet Pills _____ Sleeping Pills _____ Diuretics _____ Nutrasweet
 _____ Aspirin _____ Motrin _____ Ibuprofen _____ Advil _____ Naprosyn
 _____ Other _____
Nutrition:
 _____ Good _____ Fair _____ Poor
 Types of foods most commonly eaten: _____
 Types of foods most commonly avoided: _____
 Comments: _____

This history will become part of the permanent record.
 Completed by: _____ Relationship to patient _____ Date: ____ / ____ / ____
 Reviewed by: _____ Date: ____ / ____ / ____



Gastrointestinal Associates, P.A.

Diplomats of the American Board of Internal Medicine and Gastroenterology

Gastrointestinal Associates, P.A. CONSENT TO LEAVE INFORMATION

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- FAX (913) 492-2432

KC-GI.COM

Dear Patient,

Gastrointestinal Associates has adopted a policy that requires their staff to obtain authorization from the patient to leave detailed messages for the patient if they are not available. This policy is to protect the privacy of the patient and also to protect Gastrointestinal Associates and its staff from violating the patient's confidentiality. If there is not a signed consent on file, our staff will only leave their name and phone number on an answering machine, voice mail, or with the person answering the phone asking the patient to return the call.

By completing the consent form below, you are allowing the staff of Gastrointestinal Associates to leave a detailed message on an answering machine, voice mail or with a specified individual. You can specify what information can be left and with whom. By signing the form you are also consenting to the mailing or faxing of any results requested by you, your primary care physician or another physician involved in your care.

I give my consent to the staff of Gastrointestinal Associates to leave a message regarding treatment, lab results, radiology results, or any other information necessary.

- On an answering machine or voice mail, cell phone or via email at home.
- On an answering machine or voice mail, cell phone or via email at work.
- I do not consent to messages being left at home, work, or with any other person. I wish to be contacted directly.

The following individuals may discuss my care and financial responsibilities with Gastrointestinal Associates, P.A.

With _____ Relationship _____ Phone _____
With _____ Relationship _____ Phone _____

Patient Signature _____
Date _____

Witness _____ Date _____

GA147

Gastrointestinal Associates
Financial Policy

Gastrointestinal Associates, PA contracts with several insurance programs. If you would like for our office to file an insurance claim for your services, it is your responsibility to present a current insurance card at the time of service. We will file claims for primary and secondary insurances. We are pleased to be able to provide this service for you, however it is **your** responsibility to inform our office of your insurance policy restrictions and guidelines in regard to how often and where you may receive services. If your insurance policy requires prior authorization or a referral from a primary care physician, it is your responsibility to obtain that information. If your insurance policy requires that you select a physician from a list of providers, it is your responsibility to schedule your appointment with a provider on that list.

Unfortunately, if you do not inform us of requirements in your insurance policy or obtain your referral and we order services such as lab work, endoscopic procedures or hospitalization, that are not covered, we or the medical facility will have no choice but to bill you directly for those charges. Payment of those charges is your responsibility.

Co-payments for office visits are due in full at time of service. Patients with no insurance must contact our business office at 913-541-0510 **prior** to your appointment to make satisfactory payment arrangements. Our business office will call to verify insurance benefits on all scheduled procedures. We will estimate the patient responsibility and contact you with that information. The patient responsibility is an **estimate** based on information received from your insurance company it is not a guarantee of payment in full. The patient responsibility, which includes deductible and co-insurance, is due **prior** to your procedure.

Gastrointestinal Associates will follow up on unpaid insurance claims. However, your policy is an agreement between you and your insurance company and it is your responsibility to assure that claims for your services here are paid.

Gastrointestinal Associates does **not** file claims to auto or liability insurance. All charges are due at the time of service and we will provide you with the information you need to file a claim for reimbursement from the insurance company.

Gastrointestinal Associates does not charge interest on unpaid account balances. We are glad to set up a monthly payment schedule on balances over \$100.00, however, we are unable to finance balances for longer than 6 months. Therefore, please be aware that any monthly payment plan for deductibles and balances after insurance will only be extended for 6 months from the date the insurance payment is received. This arrangement is not available for Remicade balances or balances due before a scheduled procedure. In the event your balance is not paid timely and we must employ a collection agency or attorney, all fees associated with collection will be the responsibility of the patient.

I have read and understand the financial policy stated above and agree to accept responsibility as described.

_____ signature

_____ date