Gastrointestinal Associates, LLC.

Patient Registration Form

- ☐ Return this paperwork immediately to 10116 W. 105th St. Overland Park, KS 66212
- ☐ Bring these forms with you to your appointment
  Appointment Date: _____

- ☐ John A. Thesing, M.D.
- ☐ James A. Mavec, M.D.
- ☐ Jeff L. Young, M.D.
- ☐ Randal L. Brown, M.D.
- ☐ J. Chris Nichols, M.D.
- ☐ Christian C. McElhinney, M.D.
- ☐ John B. Sturgeon, M.D.
- ☐ Dushyant Singh, M.D.
- ☐ Donald J. Martin, M.D.
- ☐ Jessica A. Taylor, PA-C
- ☐ Kelci Gillenwater, APRN
- ☐ Celeste McGlamery, APRN
- ☐ Tracy Hill, APRN

Please PRINT & complete ALL selections:

Patient Name: _____ Date of Birth: _____

SSN: _____ Sex: Male/Female Marital Status: _____

Address: _____Apt_____ City: _____ State: _____ Zip: _____

Home Phone: _____Cell Phone: _____

Email: _____

Race: ☐White ☐Black/African-American ☐Amer. Indian/Alaskan Native ☐ Asian ☐Hawaiian/Other Pacific Island ☐Other Race

Ethnicity: ☐Hispanic or Latino ☐Non-Hispanic or Latino ☐Decline to Specify ☐Unknown Language:_____

Employer Name: _____ Work Phone: _____

Emergency Contact Name: _____ Relationship: _____

Home Phone: _____ Cell: _____ Work: _____

Primary Care Physician:	Phone Number: Fax Number:

Primary Insurance:	Member ID:	Group #:
Policy Holder's Name:	***Relationship:***	***DOB:***
Claims Mailing Address:		

Secondary Insurance:	Member ID:	Group #:
Policy Holder's Name:	***Relationship:***	***DOB:***
Claims Mailing Address:		

Authorization of Treatment: While I am here I permit the employees, healthcare provider, and all other persons caring for me to treat me in ways they judge beneficial to me. I understand the attending healthcare provider will explain to me the nature of my condition and his/her recommended treatment and 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 by me in applying under Title XVIII 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 as needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits to the healthcare provider or organization to submit a claim to Medicare for payment to them.

All Other Insurance: Authorization is hereby granted to Gastrointestinal Associates, LLC to release medical records and required information as requested for completion of my claims to my insurance company. I further authorize payment for medical benefits to be made directly to Gastrointestinal Associates, LLC.

CONTINUE ON BACK SIDE →

Patient Name: _____
Date of Birth: _____

COMMUNICATION AUTHORIZATION

METHOD OF DISCLOSURE:

In general, the HIPAA privacy rules give individuals the right to request a restriction on uses and disclosures of the protected health information. Please indicate how you wish to be contacted for scheduling reminders, financial information and test results (check all that apply):

☐ Home phone:	☐ Detailed message	☐ General message with call back # only
☐ Cell phone:	☐ Detailed message	☐ General message with call back # only
☐ Work phone:	☐ Detailed message	☐ General message with call back # only

PERMISSION TO DISCLOSE PROTECTED HEALTH INFORMATION

I hereby allow Gastrointestinal Associates, LLC, to disclose my protected health information to the following people because they are involved with my health care or payment. This consent will be considered valid until such time that I revoke it. It will be my responsibility to keep this information up to date, as I recognize that relationships may change.

Name:	Relationship:	Contact #:

FINANCIAL POLICY

Gastrointestinal Associates, LLC contracts with multiple insurance programs. If the patient wants us to file an insurance claim for services, a current insurance card(s) must be presented at the time of service. We will file claims for primary and secondary insurances. If patient's insurance policy has restrictions and guidelines regarding frequency and facilities, patient must inform us. If patient's insurance requires prior authorization or a referral from another doctor, it is patient's responsibility to obtain that information. If patient's insurance requires patient to select from an approved list of providers it is the patient's responsibility. If we are not informed of restrictions, prior authorization, or referral requirements prior to services, patient will be billed directly for those charges.

Co-payments for office visits are due in full at the time of service. Patients without insurance should be prepared to pay at the time of service for an office visit and prior to a scheduled procedure. We will collect a minimum baseline amount of $100.00 for self-pay at check-in. The remaining balance will be billed to the patient with the expectations of payment due on time. As a courtesy, our business office will verify benefits for the physician portion ONLY on scheduled procedures. We will contact the patient with the **estimated** amount owed prior to the procedure. 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 coinsurance, is due **prior** to the procedure.

Appointments cancelled without 48 hour notice or a no show to an appointment may be subject to a fee. Such fees are not covered by insurance and will be charged directly to the patient.

Gastrointestinal Associates, LLC, will follow up on unpaid insurance claims. However, patient's policy is an agreement between the patient and his/her insurance company and it is patient's responsibility to assure that claims for services are paid. We do NOT file claims to auto or liability insurance. We do not contract with any health share plans or health share ministries. All charges are due at the time of service and we will provide patient with the information needed to file a claim for reimbursement from the insurance company.

We are glad to set up a monthly payment schedule on balances over $100.00, however, we do not finance balances for longer than 6 months from the date the insurance payment is received. This arrangement is NOT available for Remicade balances or balances due prior to a scheduled procedure. In the event patient's balance is not paid in a timely manner and we employ a collection agency or attorney, all fees and interest associated with collection will be the responsibility of the patient.

I understand that I am personally responsible for all services provided by Gastrointestinal Associates, LLC.
I have read and understand the financial policy stated above and agree to accept responsibility as described.
I understand my disclosure of health information & any changes must be made in writing.
By signing below I agree & acknowledge the following terms & that all information provided is accurate.

_____	_____	_____
Patient Signature	***Patient Representative Signature/Relation***	***Date***

Gastrointestinal Associates, LLC
Diplomats of the American Board of Internal Medicine and Gastroenterology

Patient Name: _____

Date of Birth: _____

Date: _____

History of Present Illness

Initial Symptoms: _____
Date of Onset: _____
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

Review of Systems

Check those which have occurred recently:

General
___Weight gain
___Weight loss
___Weakness
___Fatigue
___Fever
___Chills
___Night sweats
___Fainting
___Dizziness

Gastrointestinal
___Abdominal pain
___Nausea
___Vomiting
___Bloating
___Belching
___Heartburn
___Irregular bowel habits
___Constipation
___Diarrhea
___Gas
___Hemorrhoids
___Hernia
___Poor appetite
___Food intolerances
___Blood in stool
___Black stools

Lungs
___Cough
___Phlegm
___Blood in sputum
___Short of breath
___Wheezing
___Pain
___Congestion
___Inhalant exposure

Genitourinary
___Urgency
___Incontinence
___Straining
___Back pain
___Frequent voiding
___Stones
___Burning
___Blood in urine
___Small stream
___Discharge
___Sores
___Impotence
___Dribbling

Musculoskeletal
___Muscle pain
___Muscle weakness
___Muscle cramps
___Joint pain/swelling
___Back pain

Skin
___Color changes
___Nail changes
___Hair changes
___Mole changes
___Rashes
___Itching
___Sores
___Dryness

Mouth
___Bleeding gums
___Sores
___Dental problems
___Pain
___Bad breath
___Loss of taste
___Dry mouth
___Ulcers
___Blisters

Heart
___Murmur
___Palpitations
___Rapid heart beat
___Swollen legs
___Cold extremities
___Chest pain
___Chest pressure
___Varicose veins
___Blood clots

Neurological
___Seizures
___Dizziness
___Sensory loss
___Paralysis
___Memory loss
___Numbness

Head
___Headaches
___Injuries
___Bumps/lumps

Throat
___Soreness
___Hoarseness
___Pain
___Trouble swallowing
___Recurrent infections

Blood
___Anemia
___Low blood iron
___Easy bruising
___Easy bleeding
___Swollen nodes
___Painful nodes
___Red spots

Gynecological
___Spotting
___Menstrual cramps
___Discharge
___Itching
___Painful intercourse
___Irregular periods
___Hot flashes
___Contraception
___Age at 1st period
___Age at menopause
___Duration of cycle
___Duration of flow
___Menstrual flow
Heavy/moderate/light
LMP ___/___/____
___# of pregnancies
___# of births
___# of miscarriages
___# of abortions
___hysterectomy

Breast
___Discharge
___Lumps
___Pain
___Bleeding
___Nipple discharge
___Skin changes
___Fullness

Psychiatric
___Anxiety
___Depression
___Irritability
___Hallucinations
___Drug dependency
___Suicidal tendency

Eyes
___Blurred vision
___Cataracts
___Glaucoma
___Redness
___Itching
___Burning
___Swelling
___Pain
___Dryness
___Tearing

Ears
___Hard of hearing
___Deafness
___Ringing
___Discharge
___Earache
___Itching
___Loss of balance

Nose
___Decreased smell
___Bleeding
___Pain
___Discharge
___Obstruction
___Post nasal drip
___Deviated septum
___Sinus congestion

Neck
___Enlargement
___Stiffness
___Soreness
___Lumps
___Masses

Endocrine
___Heat intolerance
___Cold intolerance
___Voice changes
___Extreme thirst
___Breast changes

Medications & Allergies

Patient Name: _____

Date of Birth: _____

**** PLEASE TYPE OR PRINT CLEARLY ****

List ALL Prescription, Over-the-counter and Supplements

NAME	DOSAGE	FREQUENCY
EXAMPLE: Aspirin	81mg	1 time/day

Pharmacy:_____**Location:**_____

Phone:_____**Fax:**_____

☐ **No Known Drug Allergies**

ALLERGIES:	REACTION:

Past Medical History

Patient Name: _____

Date of Birth: _____

Previous Illnesses: (Check all that apply)

ANEMIA
____ Iron Deficiency
____ Vitamin B12 Deficiency
____ Other _____

BLOOD DISEASE
____ Leukemia
____ Bleeding Disorder
____ Blood Clots
____ Phlebitis
____ Clotted Veins
____ Clotting Problems
____ Other _____

CARDIOVASCULAR
____ Heart Attack
____ Heart Stents
____ Murmur
____ Hypertension
____ High Cholesterol
____ High Triglycerides
____ Angina/Chest Pain
____ Mitral Valve Prolapse
____ Atrial Fibrillation
____ Coronary Artery Disease
____ Pacemaker
____ Implanted Cardioverter
____ Other _____

COMMUNICABLE DISEASES
____ Rheumatic Fever
____ Polio
____ Parasites
____ Dysentery
____ Syphilis
____ Gonorrhea
____ HIV
____ Chlamydia
____ Other _____

ENDOCRINE
____ Diabetes Type I
____ Diabetes Type II
____ Hyperthyroid
____ Hypothyroid
____ Goiter
____ Other _____

ENT
____ Sinusitis
____ Seasonal Allergies
____ Blurred Vision
____ Cataracts
____ Sleep Apnea
____ Other _____

GASTROINTESTINAL
____ Duodenal Ulcer
____ Gastric Ulcer
____ Duodenitis
____ Hiatal Hernia
____ Gallstones
____ Pancreatitis
____ Colon Polyp
____ Diverticulosis
____ Diverticulitis
____ Ulcerative Colitis
____ Crohn's Disease
____ Hemorrhoids
____ Anal Fissure
____ Fistula
____ Irritable Bowel Syndrome
____ Bowel Obstruction
____ GERD (reflux)
____ Barrett's Esophagus
____ Gastroparesis
____ Lymphocytic Colitis
____ Collagenous Colitis
____ C. diff
____ Other _____

GENITOURINARY
____ Kidney Infection
____ Kidney Stones
____ Increased Urination
____ Prostatitis
____ Sexual Problems
____ Gynecological Problems
____ Other _____

NEUROLOGY
____ Epilepsy
____ Multiple Sclerosis
____ Stroke/CVA
____ TIA
____ Paralysis
____ Headaches
____ Other _____

PSYCHOLOGICAL
____ Depression
____ Mental Illness
____ Nervousness
____ Anxiety
____ Other _____

PULMONARY
____ Emphysema
____ Bronchitis
____ Pneumonia
____ Asthma
____ TB
____ Pleurisy
____ COPD
____ Other _____

VACCINES
____ Hepatitis A
____ Hepatitis B
____ Tetanus

MISC
____ Gout
____ Arthritis
____ Skin Problems
____ Fibromyalgia
____ Hernia-Type_____
____ Osteoporosis
____ Vitamin D Deficiency
____ Osteopenia
____ Other _____

CANCER
Type _____

LIVER
____ Jaundice
____ Hepatitis
____ A
____ B
____ C
____ Cirrhosis
____ Ascites
____ Other _____

Date of last Colonoscopy: _____

Previous Surgery

Date	Surgery	Physician/Hospital

Family History

Patient Name: _____

Date of Birth: _____

Family History Unknown/Patient Adopted ☐
Please mark all that apply

Diagnosis	Living (circle one)	Colon Cancer	Colon Polyps	Ulcerative Colitis	Crohns Disease	Ulcer	Gallbladder Disease	Hepatitis	Liver Disease/Cancer	Stomach Cancer	Pancreatic Disease/Cancer	Breast Cancer	Uterine Cancer	Celiac Disease	Other	
Father	**Y/N**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	
Mother	**Y/N**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Brother(s)	**Y/N**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	
Sister(s)	**Y/N**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Children	**Y/N**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
PG-Father	**Y/N**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	
PG-Mother	**Y/N**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
MG-Father	**Y/N**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	
MG-Mother	**Y/N**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Social History

Occupation: _____

Alcohol Use:
☐None ☐Beer (____ bottles per week) ☐Wine (____ glasses per week) ☐Hard Liquor (____ drinks per day)

Caffeine Use:
☐None ☐1-2 per day ☐3-4 per day ☐more than 5 per day

Tobacco Use:
☐Never a smoker ☐Current Every Day Smoker (_____ packs per day, _____ # of years)
☐Current Some Day Smoker ☐Former Smoker (quit date _____)
Chewing Nicotine Containing Substance (Chewing tobacco) ☐Current ☐Former

Drug Use:
☐Never ☐Currently Using IV drugs ☐Used IV drugs in the past
Recreational drug use: ☐Current ☐Former