PATIENT INFORMATION SHEET

Patient Name: _____
Last First Middle Initial

Address: _____ City/State/Zip: _____

SSN: _____ Home Phone: _____

Cell Phone: _____*REQUIRED

Email Address: _____ *REQUIRED

Gender: ☐ Male ☐ Female Date of Birth: _____ Age: _____

Emergency Contact: _____ Phone Number: _____

Who referred you? _____ Primary Care Physician: _____

Primary Insurance: _____

Policy Holder Name : _____ DOB: _____ SSN: _____

Policy Holder's Relationship to Patient: ☐ Spouse ☐ Parent ☐ Other: _____

Secondary Insurance: _____

Policy Holder Name : _____ DOB: _____ SSN: _____

Policy Holder's Relationship to Patient: ☐ Spouse ☐ Parent ☐ Other: _____

Pharmacy you use _____ City _____

Your copay and deductibles are due at the time of service. By signing this, you agree to be responsible for any charges that your insurance company does not pay after assignment is accepted. You are giving us authorization to bill Medicare and/or any other insurance company that you are covered by. This authorization applies to all occasions of service until it is revoked by the patient or an authorized representative in writing.

_____ _____

Signed by patient or authorized representative Date

PATIENT HISTORY

PATIENT NAME: _____ **ACCT NO.** _____

DATE OF BIRTH: _____ **AGE:** _____ **SEX:** _____

What is the reason you are seeing the physician today?

_____

MEDICAL PROBLEMS: (Please mark all that apply)

□ Cancer	□ Chemotherapy/Radiation	□ Bleeding Tendency
□ Colon Polyps/Colon Cancer	□ Ulcerative Colitis	□ Crohns Disease
□ Diabetes	□ High blood pressure	□ High cholesterol
□ Liver Disease/Hepatitis	□ Lung Disease	□ Defibrillator
□ Heart Attack	□ Cardiac Stent	□ Pacemaker
□ Coronary Artery Disease	□ Heart Failure	□ Diverticulitis
□ Stroke / TIA	□ Kidney Disease	□ Pancreatic Disease
□ Gallstones	□ Hernia	□ Thyroid Disease
□ Sleep apnea	□ Ulcers	□ Other _____

PAST SURGERIES:

□ Abdominal □ Rectal □ Heart: Stents Pacemaker Defibrillator

□ Other_____

Have you ever had a Colonoscopy? □ **No** □ **Yes**

If so, when/where_____

Have you ever had an Upper Endoscopy? □ **No** □ **Yes**

If so, when/where_____

Family History: (Please mark all that apply)

□ **COLON CANCER OR POLYPS** □ Pancreatic Cancer □ Esophageal Cancer

□ Celiac Disease □ Inflammatory Bowel Disorders (Crohns or Ulcerative Colitis)

Social History: (Please mark all that apply)

Tobacco use: □never □past □current □Amt daily_____

Alcohol use: □never □past □rarely □moderate □frequent □Amt daily_____

Drug use: □never □past □current □Type_____

Menstrual History: (women only)

Last Menstrual Cycle:_____ Menopause age:_____

Hysterectomy:_____ Tubal Ligation:_____

Oral contraceptives:_____

- Is there any chance that you are currently pregnant? □ No □ Yes
- If you become pregnant in the future please discuss your medical conditions and medications with your primary care physician and your OB/GYN.

Signature: _____ Date: _____

PATIENT MEDICATION LIST

ACCOUNT #	**ALLERGIES / REACTION** (IF A LONG LIST, PLEASE BRING A COPY)
PATIENT NAME:	
DOB:	

	Prescription Medication, Supplements, and Herbal Remedies and Dosage	Frequency	Last dose		Prescription Medication, Supplements, and Herbal Remedies and Dosage	Frequency	Last dose
1				21			
2				22			
3				23			
4				24			
5				25			
6				26			
7				27			
8				28			
9				29			
10				30			
11				31			
12				32			
13				33			
14				34			
15				35			
16				36			
17				37			
18				38			
19				39			
20				40			

ARE YOU TAKING A BLOOD THINNER? YES OR NO

IF YES, WHICH MEDICATION? _____

Patient Signature: _____ Date: _____

PROVIDER SIGN OFF

DATE	INITAL	DATE	INITAL

WV GASTROENTEROLOGY & ENDOSCOPY
HIPPA POLICY

Patient Name: _____ Account #: _____

Date of Birth: _____ SSN: _____

I give permission to be contacted in the following manner (please check all that apply):

- ☐ Cell: _____
- ☐ Home phone: _____
- ☐ Written communication to home
- ☐ Ok to leave a message with information
- ☐ Leave message with only call-back number
- ☐ Leave message with family members below

Person (s) allowed to receive your medical information:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

I CONSENT TO CARE AND TREATMENT
I consent to examination, treatment, and testing by my attending physician, facility personnel or authorized agents who may be involved in my care.

I CONSENT TO USE/DISCLOSURE OF MY MEDICAL INFORMATION
I authorize the use and disclosure of my medical information, including information relating to AIDS and the results of HIV-testing; drug or substance abuse; and mental health related treatment and services for the purpose of treatment, payment and/or healthcare operations.

I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES
I have received my provider's Notice of Privacy Practices, which tells how my health information may be used and shared. I understand that my provider reserves the right to revise the notice at any time, and that I can always get the current copy by asking for it.

INSURANCE PAYMENTS DIRECTLY TO THE FACILITY
I authorize my provider or any facility providing services to me to directly bill and collect payment from my insurance company, Medicare, Medicaid, or other company that pays my medical bills. I understand that I may receive a separate bill for radiology or laboratory services provided by another facility. I certify that all information given by me in applying for payment by any third party is true and accurate.

I AGREE TO PAY FOR THE COST OF CARE AND TREATMENT AT TIME OF SERVICE
I accept responsibility for the cost of all services provided to me. I understand that I may have to pay charges that are not paid by my insurance company or anyone else. I will pay the collection costs, including court costs; if legal action must be taken to collect my unpaid bill.

_____ _____

PATIENT SIGNATURE **DATE**

West Virginia Gastroenterology & Endoscopy

Patient Name:

Patient DOB:

Chronic Care Management Consent

Chronic care management is a medicare/private insurance covered service at NO cost to you and is highly recommended as a vital addition to your overall care.

This extra layer of care has been shown to keep you healthier and improve clinical outcomes.. You will be furnished with a 24/7 contact to a care coordinator that will work directly with you. The care coordinator will contact you from time to time to develop care plans, assist with any prescription refills and help with any other medical needs. This program will keep your entire healthcare team informed of your ongoing health between appointments

Please see the following below particulars about the program.

1. I understand the nature of CCM, as explained by my provider.

2. I understand how CCM may be accessed.

3. I understand I can terminate the agreement at any time.

4. I understand that my protected health information may be shared with other providers taking care of you for care coordination purposes.

_____ _____

Patient's Signature Date

Name:
ACCT #:

Please check the following as it pertains to you and sign below.

- ○ I have **Mitral Valve Prolapse**
- ○ I have **Heart Stents** Last stent date: _____
- ○ I have **Heart Murmur**
- ○ I have a **Defibrillator / Pacemaker**
- ○ I have an **Artificial Heart Valve**
- ○ I am under the care of a cardiologist for a heart condition other than above
- ○ My cardiologist is : Dr. _____ Phone Number: _____

  I was last seen: _____ My next appt is scheduled for: _____
- ○ Although I am under the care of a cardiologist or pulmonologist, I **deny** any issues with my condition(s) within this past year
- ○ I have a condition that requires antibiotics before invasive procedures
- ○ I take **Coumadin/Plavix (Clopidogrel)**/Pradaxa/Xarelto/**Eliquis**/Brilinta/Effient or another form of blood thinner
- ○ I understand that my Plavix (Clopidogrel) and/or Coumadin may have to be stopped for 2-7 days before my procedure as directed by my Primary Care doctor or Cardiologist
- ○ I have a known drug allergy to **Penicillin**
- ○ I have a known drug allergy to **Iodine / IV Contrast Dye / Shellfish**
- ○ I have a history of **C. Diff / VRE / MRSA**
- ○ I am a diabetic and understand that I do not take my diabetic medication / insulin on the day of the procedure until after I start eating
- ○ I have history of intolerance to standard sedatives
- ○ I am on chronic narcotics or benzodiazepines
- ○ I am over 70 years old
- ○ I am pregnant
- ○ I have history of alcohol or drug abuse
- ○ I have sleep apnea and require CPAP machine
- ○ I am over 350 lbs
- ○ I have been told I am a high risk sedation patient
- ○ I do **NOT** have any of the conditions listed above and do not take any blood thinning medications

Signature: _____ Date: _____