Alabama Digestive Diseases

PATIENT DATA, PAGE 1
FORM MUST BE COMPLETED IN FULL (Please Print)

Name_____ Today's Date_____

Social Security No._____ Date of Birth_____

Marital Status □ Married □ Single □ Widowed □ Divorced Gender □ Male □ Female

Home Address _____
Street City State Zip

Phone Numbers: Home_____ Cell_____ Work_____

Email Address_____ Preferred Contact Method □ Phone □ Mail □ Email

EMPLOYMENT

Employer_____ Dept./Title_____

Employer's Address_____
Street City State Zip

Employer's Phone_____

EMERGENCY CONTACTS

Spouse/Companion/Guardian:

Name & Relationship_____ Phone_____

Address_____
Street City State Zip

Nearest relative or friend not living with you:

Name & Relationship_____ Phone_____

Address_____
Street City State Zip

FAMILY PHYSICIAN

Name_____ Phone_____

PREFERRED PHARMACY

Pharmacy Name_____ Phone_____

Pharmacy Address_____
Street City State Zip

REFERRAL

Referred to Alabama Digestive Diseases by_____

Address/Phone_____
Street City State Zip Phone

PERSON RESPONSIBLE FOR PAYMENT

Name_____ Phone_____

Address_____
Street City State Zip

INSURANCE INFORMATION

Primary_____ Policy No._____ Group No._____

Name of Insured & Relationship_____ DOB_____

Secondary_____ Policy No._____ Group No._____

Name of Insured & Relationship_____ DOB_____

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY

Correctness of Information on Page 1: _____ (*initial*)
I certify that the above information is correct.

Professional Services: _____ (*initial*)
I understand that I am a patient of ALABAMA DIGESTIVE DISEASES, P.C., and that they have the right to designate the person(s) who will perform professional services for me.

Authorization for Release of Medical Information: _____ (*initial*)
The hospital and attending physician are authorized to furnish medical information requested by insurance companies with whom I have coverage or any public agency which may be assisting in payment of my care.

Assignment of Insurance Benefits: _____ (*initial*)
I authorize payment of medical benefits to ALABAMA DIGESTIVE DISEASES, P.C., and authorize them to release any medical information necessary to process claims. I understand that I am responsible for co-payments, deductibles, co-insurance and non-covered services.

Patient / Guarantor Name_____
Please Print

Patient / Guarantor Signature*_____ **Date**_____
**If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.*

Alabama Digestive Diseases

PERSONAL HISTORY
NEW PATIENT

Today's Date_____

1) Name_____ Age_____ Date of Birth_____

2) Referred by_____ Primary Care Physician_____

3) Other physicians involved in your healthcare_____

4) Describe the reason(s) for your visit_____

_____

MEDICATIONS - Please list all of your current prescription and non-prescription medications, vitamins and supplements.

☐ None

PAST MEDICAL HISTORY

- ☐ Acid reflux
- ☐ Anal fissure
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial heart valve
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Blood clots
- ☐ Blood transfusion
- ☐ Cancer
- ☐ Chest pain / angina
- ☐ Chronic anxiety
- ☐ Chronic cough
- ☐ Chronic lung disease
- ☐ Chronic sinusitis
- ☐ Cirrhosis of liver
- ☐ Colon cancer
- ☐ Colon polyps
- ☐ Crohn's disease
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Duodenal ulcer
- ☐ Emphysema
- ☐ Fatty liver
- ☐ Gallstones
- ☐ Glaucoma
- ☐ Gout
- ☐ Groin hernia
- ☐ Heart attack
- ☐ Heart failure
- ☐ Heart murmur
- ☐ Hepatitis
- ☐ Hiatal hernia
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ High triglycerides
- ☐ HIV or AIDS
- ☐ Irregular heart beat
- ☐ Irritable bowel syndrome
- ☐ Kidney disease / failure
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Lupus / Scleroderma
- ☐ Migraines
- ☐ Milk intolerance
- ☐ Mitral valve prolapse
- ☐ Multiple sclerosis
- ☐ Osteoporosis
- ☐ Ovarian cyst
- ☐ Pacemaker
- ☐ Pancreatitis
- ☐ Parkinson's disease
- ☐ Peptic ulcer
- ☐ Phlebitis
- ☐ Pneumonia
- ☐ Polio
- ☐ Psoriasis
- ☐ Radiation therapy
- ☐ Rheumatic fever
- ☐ Sciatica
- ☐ Seizures
- ☐ Sleep apnea
- ☐ Stomach ulcer
- ☐ Stroke or paralysis
- ☐ Tuberculosis (TB)
- ☐ TB skin test positive
- ☐ Thyroid disease
- ☐ Ulcerative colitis

ALLERGIES

☐ NONE ☐ Penicillin ☐ Sulfa ☐ Aspirin ☐ Iodine ☐ Latex ☐ Others _____

SURGERIES / PROCEDURES

- ☐ NONE
- ☐ Appendectomy
- ☐ Breast
- ☐ Colon surgery
- ☐ Colonoscopy
- ☐ Colostomy
- ☐ C-section
- ☐ EGD
- ☐ ERCP
- ☐ Gallbladder
- ☐ Groin hernia
- ☐ Heart bypass
- ☐ Heart stent
- ☐ Heart valve
- ☐ Hemorrhoid surgery
- ☐ Hiatal hernia repair
- ☐ Hysterectomy
- ☐ Joint replacement
- ☐ Kidney
- ☐ Liver biopsy
- ☐ Obesity surgery
- ☐ Ovary
- ☐ Prostate
- ☐ Sigmoidoscopy
- ☐ Stomach
- ☐ Thyroid
- ☐ Tonsillectomy
- ☐ Tubal ligation
- ☐ Uterus
- ☐ OTHER

PREVIOUS HOSPITALIZATIONS

Reason	Date	Reason	Date

FAMILY HISTORY

	Father	Mother	Grandparents	Siblings	Children
Healthy	☐	☐	☐	☐	☐
Deceased	☐	☐	☐	☐	☐
Colon polyps	☐	☐	☐	☐	☐
Colon cancer	☐	☐	☐	☐	☐
Ulcer disease	☐	☐	☐	☐	☐
Liver disease	☐	☐	☐	☐	☐
Pancrease disease	☐	☐	☐	☐	☐
Crohn's disease	☐	☐	☐	☐	☐
Ulcerative colitis	☐	☐	☐	☐	☐
Stomach cancer	☐	☐	☐	☐	☐
Diabetes mellitus	☐	☐	☐	☐	☐
Heart attack	☐	☐	☐	☐	☐
Breast cancer	☐	☐	☐	☐	☐
Other cancer	☐	☐	☐	☐	☐

SOCIAL HISTORY

Marital status ☐ married ☐ single ☐ divorced ☐ widowed

Occupation _____ ☐ unemployed ☐ retired

Smoking history ☐ never ☐ yes, _____ packs per day for _____ years

Currently smoking ☐ no ☐ yes

Other tobacco use ☐ no ☐ yes; details _____

Alcohol use (beer, wine, liquor) ☐ no ☐ yes; amount per day:_____ for _____ years

IV or recreational drug use ☐ no ☐ yes; specify drugs and amounts: _____

Exercise ☐ no ☐ yes; how much and how often: _____

Hobbies ☐ none ☐ yes; specify: _____

Recent travel outside U.S. ☐ no ☐ yes; where:_____

REVIEW OF SYSTEMS *(check all that apply at the present time)*

General
- ☐ fever or chills
- ☐ loss of appetite
- ☐ unintentional weight gain
- ☐ unintentional weight loss
- ☐ weakness, fatigue

Gastrointestinal
- ☐ abdominal distention
- ☐ abdominal pain/cramping
- ☐ belching
- ☐ black stools
- ☐ blood in stool / rectal bleeding
- ☐ change in bowel habits
- ☐ constipation
- ☐ diarrhea
- ☐ difficulty swallowing
- ☐ fat intolerance
- ☐ full after eating small amounts
- ☐ gas/bloating
- ☐ heartburn
- ☐ indigestion
- ☐ hemorrhoids
- ☐ jaundice (yellowing of eyes or skin)
- ☐ mucus in stool
- ☐ nausea or vomiting
- ☐ pain with swallowing

Gastrointestinal *(cont'd.)*
- ☐ poor appetite
- ☐ rectal bleeding
- ☐ rectal pain or itching
- ☐ regurgitation of food
- ☐ soiling / incontinence
- ☐ vomiting blood

Cardiovascular
- ☐ chest pain or tightness
- ☐ rapid or irregular heart beat
- ☐ swelling of legs
- ☐ varicose veins

Respiratory
- ☐ chronic cough
- ☐ wheezing
- ☐ shortness of breath
- ☐ need for oxygen therapy

Urinary
- ☐ pain or difficulty with urination
- ☐ frequent urination
- ☐ blood in urine
- ☐ incontinence of urine

Musculoskeletal
- ☐ stiff or painful joints
- ☐ swollen joints
- ☐ back pain
- ☐ muscle pain

Hematologic
- ☐ frequent bruising
- ☐ bleeding doesn't stop easily

Endocrine
- ☐ heat or cold intolerance
- ☐ excessive thirst or urination
- ☐ steroid therapy (prednisone)

Dermatologic
- ☐ rash or hives
- ☐ itching
- ☐ tattoos

Gastroreproductive - MALE
- ☐ discharge from penis
- ☐ testicular pain or lump

Gastroreproductive - FEMALE
- ☐ heavy periods

Date of last period _____

Ear, Eyes, Nose, Mouth, Throat
- ☐ hearing loss
- ☐ ear pain / ringing
- ☐ mouth ulcers / sores
- ☐ poor dentition
- ☐ nose bleeds
- ☐ visual changes
- ☐ enlarged or swollen glands

Neurologic
- ☐ numbness or tingling
- ☐ dizziness or lightheadedness
- ☐ vertigo
- ☐ headaches
- ☐ weakness in arms or legs
- ☐ blurred vision
- ☐ difficulty with memory

Psychiatric
- ☐ anxiety
- ☐ depression
- ☐ panic attacks
- ☐ tired on waking up in morning

Immunizations
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Pneumovax

Reviewed by Doctor _____ Date _____

Alabama Digestive Diseases

NOTICE OF PRIVACY PRACTICES

Alabama Digestive Diseases, P.C. presents this Notice to our patients describing how your medical information may be used or disclosed, and how you can get access to this information. Please review it carefully. You have the right to obtain a paper copy of this Notice upon request.

Patient Health Information
Under Federal law, your patient health information is protected and confidential. Patient helath information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also inculdes payment, billing, and insurance information.

How We Use Your Patient Health Information
Alabama Digestive Diseases, P.C. uses health information about you for treatment, analyzing procedures, and lab results. We use information to obtain payment and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, where the law applies, we may be required to use or disclose the information without your permission.

Examples of Treatment, Payment, and Health Care Operations

Treatment: Alabama Digestive Diseases, P.C. will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your medical record and use it to determine the most appropriate course of care. We may also disclose this information by fax, in person, or via telecommunication. We may communicate to other health care providers who are participating in your treatment, to pharmacists who are filling and refilling your prescriptions, and to family members who are helping with your care.

Payment: Alabama Digestive Diseases, P.C. will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treament. We will submit bills and maintain records of payments from your health plan.

Health Care Operations: Alabama Digestive Diseases, P.C. will use and disclose your health information to conduct our standard internal operations, including proper administration records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Release of Information to Family or Friends
Alabama Digestive Diseases, P.C. knows that family or friends are an integral part of a patient's care. If you wish to authorize a family member or friend to speak with us regarding your care or test results, please write their name and contact information on the "Notice of Privacy Practices Acknowledgement" form. We will not release your information to any friend or family without your written consent.

Special Uses
Alabama Digestive Diseases, P.C. may use your information to contact you with appointment reminders by phone, mail, or email. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. This communication may be sent to you via the methods listed above. If you have granted written permission, the above information may also be sent to you via email. If you wish to authorize the use of email as a method for us to communicate with you, sign the proper section on the "Notice of Privacy Practices Acknowledgement" form.

Other Uses and Disclosures
Alabama Digestive Diseases, P.C. may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:

- **Required by Law**
  We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
- **Research**
  We may use or disclose information for approved medical research.
- **Public Health Activities**
  As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
- **Health Oversight**
  We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
- **Jucidial and Administrative Proceedings**
  We may disclose information in response to an appropriate subpoena or court order.
- **Law Enforcement Purposes**
  Subject to certain restrictions, we may disclose information required by law enforcement officials.
- **Deaths**
  We may report information regarding deaths to coroners, medical examiners, funeral, and organ donation agencies.
- **Serious Threat to Health of Safety**
  We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **Military and Special Government Functions**
  If you are a memeber of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.

- **Workers' Compensation**
  We may release information about you for workers' compensation or similar programs providing benefits for work-related injuries or illness. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights
You have the following rights with regard to your health information. Submit any concerns in writing to the Alabama Digestive Diseases, P.C. Compliance Officer (see below).

- **Request Restrictions**
  You may request restrctions on certain uses and disclosure of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.
- **Confidential Communications**
  You may ask us to communicate with you confidentially. Please ask to see the Alabama Digestive Diseases, P.C. Office Manager to initate and document this request.
- **Inspect and Obtain Copies**
  You have the right to see or receive a copy of your health information. There may be a small charge for these copies.
- **Amend Information**
  If you believe information in your record is incorrect, you have the right to request that we correct or amend the existing information. Your physician has the right to refuse your request.
- **Accounting of Disclosures**
  You may request a list of instances where we have disclose health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices
We may change our policies at any time. A current version of our Notice is available in each waiting area at all times. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints
If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person lsited below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

If you have any questions, requests, or complaints, please contact Alabama Digestive Diseases, P.C. Complaince Officer:

Alabama Digestive Diseases, P.C.
Attn: Compliance Officer
985 9th Avenue, SW, Suite 307
Bessemer, AL 35203
(205) 481-7384

THIS NOTICE IS EFFECTIVE ON OR AFTER APRIL 14, 2003

Alabama Digestive Diseases

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT OF RECEIPT

I, _____, hereby acknowledge that Alabama Digestive Diseases, P.C. has given me the opportunity to read a detailed notice of their Privacy Practices.

_____ Date_____

Signature of Patient/Authorized Representative * *If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.*

If not signed, please provide a reason why the acknowledgement was not obtained.

_____

_____

Witness / Staff Signature

CONSENT TO RELEASE INFORMATION

In the event I cannot be reached, I, _____, give permission for a representative of Alabama Digestive Diseases, P.C. to speak with family member(s) or companion(s) listed below regarding care or test results.

Name _____ Phone _____

Relationship _____

Name _____ Phone _____

Relationship _____

Is it OK to leave results or information on your voice-mail/answering machine? ☐ Yes ☐ No

_____ Date _____

Signature of Patient/Authorized Representative * *If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.*

CONSENT TO CORRESPOND ELECTRONICALLY

While Alabama Digestive Diseases, P.C. takes reasonable precautions to protect your confidential information, email is not a completely secure method of communication.

I acknowledge that if I use electronic mail to initiate contact with an Alabama Digestive Diseases physician regarding my medical care, the physician and/or his/her representative has my permission to correspond via that email address.

I give permission for an Alabama Digestive Diseases physician or clinical staff member to email regarding my medical care at:

_____ @ _____

_____ Date _____

Signature of Patient/Authorized Representative * *If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.*