GASTROENTEROLOGY CONSULTANTS CFL, PA

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PATIENT REGISTRATION & HEALTH QUESTIONNAIRE

REGISTRO DE PACIENTES & CUESTIONARIO DE SALUD

Name (Nombre): _____ **Gender** (Genero): **Female** **Male**

Date of Birth (Fecha de Nacimiento): _____

Marital Status (Estado Civil): **Single** (soltero/a) **Married** (Casando/a) **Widow** (Viudo/a)
Divorced (Divorciado/a) **Separated** (Separado/a)

S.S# (Número Seguro Social): _____

Email (Correo electrónico): _____

Race: **White/Caucasian** **African American** **Asian** **American Indian/Alaska Native**
Unreported/Refused to report **other** _____

Ethnicity: **Hispanic/Latino** **Non-Hispanic/Latino** **Unreported/refused to report**
Other_____

Preferred Language (Lenguaje de Preferencia):_____

Address (Direccion):_____

City (Ciudad):_____ **State** (Estado):_____ **Zip** (Código Postal):_____

Home# (Numero del hogar):_____

Cell# (Numero celular):_____

Work# (Numero de Trabajo):_____

Occupation (Occupacion):_____

Spouse's Name (Nombre del cónyuge):_____

Date of Birth (Fecha de nacimiento):_____ **Contact #**(Numero de contacto):_____

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OrlandoGiDoc.com

PATIENT HISTORY AND PHYSICAL FORM

PATIENT PAST MEDICAL HISTORY

(Please check any medical problems that you have had in the past)

____Anemia	____Depression	____Kidney Stone
____Anticoagulation Therapy	____Diabetes Mellitus	____Liver Disease
____Anxienty	____Fatty Liver	____Myocardial Infarction(Heart Attack)
____Arthritis	____Fibromyalgia	____ Osteoporosis
____Cancer	____GERD (Heartburn)	____Pancreatitis
____Cataracts	____Heart Disease or Pacemaker	____Primary Biliary Cirrhosis
____Chronic Lung Disease	____Hepatitis B	____Primary Sclerosing Cholangitis
____Cirrhosis	____Hepatitis C	____ Rashes / Skin Problem
____Colon Polyps	____Hyperlipidemia (High Cholesterol)	____ Renal Insufficiency
____Congestive Heart Failure	____Hypertension (High Blood Pressure)	____ Sleep Apnea
____Coronary Artery Disease	____Inflammatory Bowel Disease	____ Thyroid Disease
____Crohn's Disease	____Irritable Bowel Syndrome	____ Ulcerative Colitis
____Deep Vein Thrombosis	____Kidney Disease	____ Other (specify)
		_____

PAST SURGICAL HISTORY

Check any surgeries you have had and the date of surgery if you know it.
___ Never had a Surgery.

____Appendectomy _____	____Cosmetic Surgery _____	____Hysterectomy _____
____Bariatric Surgery _____	____C- Section _____	____Kidney Transplant_____
____Bowel Resection_____	____Eye Surgery _____	____Liver Transplant_____
____Breast Surgery _____	____Heart Surgery_____	____Orthopedic Surgery _____
____Cholecystectomy (Gallbladder Removal) _____	____Hepatobiliary Surgery _____	____Sterilization _____
____Colonoscopy _____	____Hernia Repair_____	____Vascular Surgery_____
____Upper Endoscopy (EGD)_____	____Other (specify)_____	

FAMILY HISTORY

Check below to report problems your FAMILY MEMBERS have had.
____ I was adopted so I do not know my FAMILY HISTORY.

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Alcohol Abuse						
Breast Cancer						
Cancer						
Celiac Disease						
Colon Cancer						
Colon Polyps						
COPD (Lung Disease)						
Cystic fibrosis						
Diabetes						
Heart Attack						
High Cholesterol						
Hypertension						
Inflammatory Bowel Disease						
Irritable Bowel Syndrome						
Kidney Disease						
Liver Disease						
Other (specify)						
Alive (Yes, No, or N/A= No Applicable						

MEDICATION

	Medication	Dosege	Frequency	Indication
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Pharmacy (Farmacia): _____
Location (Localidad): _____
Pharmacy Phone# (Numero de Farmacia): _____
Allergies (Alergias):_____

EMERGENCY CONTACT/CONTACTO DE EMERGENCIA

Name/Nombre: _____
Relation to patient/ Relacion al paciente: _____
Phone#/Numero de contacto: _____
Address/Direccion: _____
City/Ciuda: _____ State/Estado: _____ Zip/codigo: _____

PRIMARY CARE PHYSICIAN/ MEDICO PRIMARIO

Doctor's Name/ Nombre del médico: _____
Office#/ # Oficina: _____ Fax# _____
Address/Direccion: _____
City/Ciuda: _____ State/Estado: _____ Zip/codigo: _____

REFERRING PHYSICIAN/ REFIRIÉNDOSE MÉDICO

Doctor's Name/ Nombre del médico: _____
Office#/ # Oficina: _____ Fax# _____
Address/Direccion: _____
City/Ciuda: _____ State/Estado: _____ Zip/codigo: _____

FINANCIAL POLICY

The doctors and staff of Gastroenterology Consultants, CFL, PA would like to welcome you to our practice. We strive to provide you with excellent medical care and our goal is to make your visit as convenient as possible. We ask for help by understanding and cooperating with our financial policy.

Please read this policy and sign below confirming you understand the following:

- All payments – Self pay fee, insurance co-payments, co-insurances and deductibles will be collected at the time of service. Payable by Cash, Check, Visa, MasterCard, Discover or American Express

- A return check will result in a $25 service charge and all future payments will be required in the form of Cash or Credit Card.

- If you do NOT have your payment; your appointment may be re-scheduled.

- Payment in full of any past due balance is expected prior to being seen.

- Our practice participates with several insurance companies; it is your responsibility to understand the requirements and covered benefits of your plan.

- You are responsible for any non-covered and/ or denied claim; you will receive a statement of denied charges and payment is due in 30 days after the date of statement.

- If you insurance policy requires a referral, it is your responsibility to contact your primary care physician and have a referral faxed to our office prior to appointment date.

- It is your responsibility to notify our office of any changes to your insurance coverage, your address and telephone number.

- You are required to cancel your appointment 24 hours prior to the appointment time. No shows and late cancellation are subject to a $50 cancellation charge for office visits and $100 cancellation charge for procedures.

We realize that temporary financial problems may affect timely payment of accounts. If such problem arise, we urge you to contact us promptly for assistance in the management of your account. Call 407-292-1414.

I have read and understand the above financial policy and agree to meet all financial obligations.

Patient Name (Print): _____ Date: _____

Patient Signature: _____

***Para esta información en español por favor de solicitarla en la oficina**

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/ medical benefits to Gastroenterology Consultants, for services rendered by him/ her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance/s.

Español: *Por la presente autorizo el pago directo de beneficios médicos / procedimiento a Gastroenterology Consultants, por los servicios prestados por él / ella en persona o bajo su / su supervisión. Entiendo que soy financieramente responsable de cualquier saldo no cubierto por mi seguro.*

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Gastroenterology Consultants to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefits.

Español: *Por la presente autorizo Gastroenterology Consultants para liberar cualquier información médica o incidental que pueda ser necesario, ya sea para la atención médica o en la tramitación de solicitudes de beneficios financieros.*

MEDICARE/ MEDICAID BENEFITS

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

Español: *Certifico que la información dada por mí en la solicitud de pago es correcta. Autorizo la liberación de todos los registros a petición. Solicito que el pago de los beneficios autorizados se haga en mi nombre.*

_____ _____

Patient Name *(Please Print)*: **Date/** Fecha:
(Nombre de paciente)

_____

Patient's Signature
Firma de Paciente