Med Center Health®
Gastroenterology

PATIENT INFORMATION (Please Print)

Patient Name _____
(Last, First, Middle Initial)

Preferred Name (Nickname) _____ Name Suffix Jr. Sr. I II III IV V Age _____

Date of Birth _____ Male/Female _____ SS# _____

Ethnicity/Race _____ Preferred Language _____ Marital Status _____

Address _____

City _____ State _____ Zip Code _____

Home Phone # _____ Cell Phone # _____ Work Phone # _____

E-mail Address: _____ Have you registered for our patient portal? Y/N

How would you like to be contacted Home Phone Cell Phone Email Text Patient Portal

Employer _____ Occupation _____

PHARMACY INFORMATION

Pharmacy Name _____ Pharmacy Location _____

PHYSICIAN INFORMATION

Primary Care Physician _____ Office Phone _____ City_____ State ___

Referring Physician _____ Office Phone _____ City_____ State ___

EMERGENCY CONTACTS

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

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SYMPTOMS: Please circle any you have been recently experiencing.

CONSTITUTIONAL: weight loss weight gain night sweats fever fatigue none

SKIN: change in size/color of mole rash cyst/lump wound itching none

EYES: poor vision double vision blurred vision glasses contacts none

ENT: sinus pain deafness/ringing in ears hoarseness nose bleed runny nose sore throat none

CARDIOVASCULAR: palpitations chest pain shortness of breath difficulty breathing lying down swelling of feet/legs leg pain with exercise none

RESPIRATORY: chronic cough coughing up sputum coughing up blood pain with breathing wheezing shortness of breath none

GI/ABDOMEN: abdominal pain loss of appetite difficulty swallowing nausea vomiting hernia diarrhea constipation tarry/bloody stools change in stools painful stools jaundice none

MUSCULOSKELETAL: muscle weakness muscle cramps stiffness bone/joint deformity one joint pain diffuse joint pain none

KIDNEY/BLADDER: pain with urination decreased urine stream blood in urine unable to urinate urinary frequency kidney failure none

NEURO: weakness seizures migraines/headaches incoordination dizziness lightheadness chronic neck/back pain tremor numbness/tingling in extremities none

PSYCH: anxiety depression hallucinations confusion sleep disturbances none

ENDOCRINE: heat intolerance cold intolerance excessive sweating excessive thirst goiter none

BLOOD AND IMMUNE: swollen lymph node easy bruising/bleeding frequent infections none

REPRODUCTIVE (MALE): groin bulge testicular pain groin pain penile discharge none

REPRODUCTIVE (FEMALE): groin bulge heavy periods irregular periods vaginal discharge none

BREAST: breast lump breast pain nipple inversion nipple discharge none

MEDICATIONS/ALLERGIES:
Please list ALL medications you take, and ALL medication allergies.

ALLERGIES (including food specific allergies or intolerances): MEDICATIONS:

_____ _____

_____ _____

_____ _____

_____ _____

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MEDICAL HISTORY: Please circle any you have/have had.

EYES: glaucoma macular degeneration other eye disease none
CARDIOVASCULAR: heart attack coronary artery disease heart failure atrial fibrillation high blood pressure high cholesterol none
RESPIRATORY: asthma smoking COPD sleep apnea lung cancer other lung disease none
GI/ABDOMEN: GERD ulcer liver disease Hepatitis B or C colon polyps colon cancer none
MUSCULOSKELETAL: arthritis fibromyalgia other MSK disease none
KIDNEY/BLADDER: kidney stones freq. urinary infections kidney failure other renal disease none
NEURO: stroke/TIA memory issues seizures chronic neck/back pain other neuro disease none
PSYCH: anxiety depression bipolar disorder other psych disease none
ENDOCRINE: diabetes thyroid disease other endocrine disease none
BLOOD AND IMMUNE: autoimmune disease bleeding disorder clotting disorder HIV tuberculosis
DVT/PE (blood clots): blood transfusions blood cancer none
REPRODUCTIVE: uterine/cervical/ovarian cancer prostate cancer BPH none
BREAST: benign breast masses breast cancer mastitis/abscess none
CANCER: other cancer not mentioned above none

SURGICAL HISTORY: Please list ALL surgeries you have had.

HAVE YOU EVER HAD A COLONOSCOPY? Y/N If yes, when? _____

HAVE YOU EVER HAD AN EGD? Y/N If yes, when? _____

LIST PREVIOUS SURGERIES: _____

_____

_____

_____

SOCIAL HISTORY: Please circle/fill out all which apply.

TOBACCO USE: smoke chew e-cigs never used HOW MUCH? _____ FORMER USER?_____ QUIT?_____
ALCOHOL USE: daily moderately rarely never used HOW MUCH? _____ QUIT? _____
DRUG USE: marijuana heroin opiates meth cocaine other never used former user QUIT? _____
EDUCATION LEVEL (or highest grade completed in school): _____

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FAMILY HISTORY: Please circle all which apply.

FATHER:	heart attack	high blood pressure	diabetes	lung disease	mental illness	other
MOTHER:	heart attack	high blood pressure	diabetes	lung disease	mental illness	other
SIBLING(S):	heart attack	high blood pressure	diabetes	lung disease	mental illness	other
GRANDPARENTS:	heart attack	high blood pressure	diabetes	lung disease	mental illness	other
CHILDREN:	heart attack	high blood pressure	diabetes	lung disease	mental illness	other

HISTORY OF GASTROINTESTINAL DISEASE: Crohn's disease Ulcerative colitis Celiac disease

HISTORY OF BREAST CANCER: Y/N If yes, who? _____

HISTORY OF COLON CANCER: Y/N If yes, who? _____

HISTORY OF OTHER CANCER: Y/N If yes, who? _____

_____ _____

Signature of Patient or Responsible Party Date

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Consent, Assignment of Benefits & Financial Agreement

Name: _____ DOB: _____

Consent to Diagnostic Tests, Medical Treatment and Procedures:
I do voluntarily consent to care involving diagnostic tests, medical treatment and procedures by the physicians/practitioners of Commonwealth Health Corporation, d/b/a MCH Gastroenterology, their assistants and designees, and other employees of MCH Gastroenterology as is necessary or advisable in their judgment. This consent includes testing for communicable diseases, including but not limited to Human Immunodeficiency Virus (HIV), hepatitis or any other blood-borne infectious disease if ordered for a diagnostic purpose or due to occupational exposure of a health care worker. I acknowledge no guarantee has been made to me as to the results of examination and treatment.

Assignment of Benefits and Financial Agreement:
I certify all information given by me is correct and I accept responsibility for the charges for the care provided. I agree to the assignment of all third-party benefits to MCH Gastroenterology and to any physician, practitioner, organization or independent contractor who provided products or services, and agree to pay all charges not covered by third-party payers. If I am covered by an ERISA plan, with this assignment I specifically authorize my providers to receive copies of all notifications and information that I am legally entitled to receive under the terms of my insurance/health plan and to act on my behalf to appeal benefit determinations. I acknowledge any claim for benefits from a third party payer may be filed by MCH Gastroenterology as a courtesy to me. However, I am primarily responsible for monitoring the filing process and making certain the claim is filed in compliance with the provisions specified by the applicable third party payer. The filing of the claim by MCH Gastroenterology in no way releases me from liability for any portion of the bill not paid by a third party payer for any reason.

Unless other payment arrangements are approved by MCH Gastroenterology, the account balance is due upon demand. Failure to pay for the services may result in the placement of an account with a collection agency or attorney for collection. All amounts due, as shown in the final statement and/or amended final statement, shall bear interest from the due date until paid at a per annum rate of eight percent (8%). In the event there is a judgment, the amount due shall accrue interest at the judgment rate of six percent (6%) until paid in full. Further, I agree to pay all costs of collection including court costs, interest, attorney fees and collection agency fees.

Contact Information:
I agree MCH Gastroenterology, Commonwealth Health Corporation and their agents, attorneys or collection agencies may contact me regarding medical information or information about my account or for the purposes of collection by telephone at any number provided by me including wireless telephone numbers, and via text messaging or e-mail to any e-mail address provided. Methods of contact may include the use of pre-recorded or artificial voice messages and/or automated dialing.

Release of Information:
I authorize the release of all or part of my records, including information stored in MCH Gastroenterology corporate-wide database, to my physician(s), whose name I provided at the time of registration, and to any physician or practitioner who has or will provide services to me. I authorize the release of statistical information as required by any local, state or federal agency or managed care program. I authorize the release of my HIV test results to health care personnel in the event of an occupational exposure.

I authorize MCH Gastroenterology and any other holder of medical or other information to release information about me (including medical information concerning psychological or psychiatric conditions, alcoholism and/or drug related conditions and HIV or other blood-borne infectious diseases) as required to complete any claim for benefits due to services rendered to me to any person or corporation which is or may be responsible for all or part of the total charge incurred. The persons or corporations to which this information may be released includes, but is not limited to insurance companies, the Social Security Administration, its intermediaries and carriers, state agencies and workers' compensation carriers, as well as the review organization employed by my employer or the employer of the insured member of my family and any corporation engaged by MCH Gastroenterology to make collection of any unpaid charges. I further authorize my employer to release to MCH Gastroenterology or any agency engaged for the purpose of collecting any unpaid charges, verification of my employment status, including the amount of salary or wages and the number of hours worked.

Information Received:

_____ (initial) I acknowledge receipt of the NOTICE OF PRIVACY PRACTICES.

_____ (initial) This authorization is valid until revoked in writing.

_____ (initial) My medical/financial information may also be released to the following person(s) _____

_____

_____

Primary Care Physician: _____

If you were sent to us by another physician, please list the physician: _____

_____ _____ _____ _____
Signature Date Time Relationship (if not patient)

_____
Witness

MCH Gastroenterology
GENERAL CONDITIONS OF ADMISSION
12/24

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TREATMENT WITH CONTROLLED SUBSTANCES

Name _____ Date of Birth _____

The physician/practitioner has discussed with me the option of treating my condition/pain with a controlled substance. By accepting the prescription for the controlled substance(s) that was prescribed to me, I acknowledge I understand there are inherent risks and benefits associated with treating my condition/pain with a controlled substance. These risks include developing drug tolerance and dependence.

It is my responsibility to take the medicine as prescribed and not more frequently than prescribed. I am not to share this medication with anyone else, including family members. The use of controlled substances can depress my senses and impact driving and work safety. It is discouraged during pregnancy, and may harm the unborn child. There is a potential for overdose, and if I suspect I have had an overdose I should call 911 or go to the emergency room as soon as possible.

The medication should be stored in a safe place, out of the reach of children, and should be properly disposed of after expiration. Any requests for refills must be made during weekday hours before the prescription has expired.

I give permission for my entire prescription history to be obtained from my pharmacy.

Witness _____ Patient Signature or Person Authorized _____

Date _____ Relationship to Patient _____

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NO SHOW POLICY

It is the policy of Med Center Health Physician Practices to monitor and manage appointment no-shows. This is necessary to ensure we are able to provide timely access for all patients. High numbers of vacant appointments delay care to all patients.

We understand that it is sometimes necessary to cancel and reschedule, and that emergencies occur. If you have an appointment with one of our providers, your appointment must be canceled or rescheduled at least 24 hours prior to the scheduled appointment time. Any patient who fails to arrive for a scheduled appointment without canceling or rescheduling that appointment at least 24 hours in advance will be considered a "no-show."

As a courtesy, an appointment email is sent out five (5) days prior to your visit; a phone call goes out two (2) days prior; and a text is sent the day of the appointment.

Our policy is that at two (2) "no-shows," the patient is sent a warning letter with the dates of their missed appointments. At three (3) "no-shows," the patient is sent a discharge letter from the practice, and must seek care at another location thereafter.

Thank you,

Med Center Health Physician Practices

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