Digestive Disease Associates, LTD

PS / SK / CC **Patient Registration Form** **DDA/HOSP**

Legal Last Name _____ Legal First Name _____ Middle Initial _____

Birth Date _____Male ____ Female _____ Social Security Number _____

Circle: Marital Status M / S / D / W Primary Language English / Spanish / Other Race Caucasian / African Amer / Asian / Other / Decline

Ethnicity Hispanic / Non-Hispanic / Other / Decline

Home Address _____City, State_____Zip Code_____

Home Phone _____Work Phone _____ Cell Phone _____

Email Address _____Preferred Communication – Home / Work / Cell

If we are unable to reach you at the above numbers, who may we reach? Name _____Phone_____

Primary Care Physician / Referring Physician _____Phone _____

Pharmacy _____Address/City_____ Phone _____

Employer _____Occupation _____

In case there is an emergency who may we contact _____Phone _____

Relationship – Spouse / Parent / Child / Other

I give ***Digestive Disease Associates*** permission to discuss my test results and/or medical records with _____

Relationship – Spouse / Parent / Child / Other

Insurance Information: All professional services rendered in the office are charged to the patient's insurance. However, the patient is responsible for fees not covered by insurance, including all deductibles and coinsurance costs. If uninsured, the patient is responsible for payment upon check-in of services being rendered.

CoPay: Specialist co-pays are due at the time of check-in for your office visit, including follow up visits. We accept cash, personal checks and all major credit cards.

Referrals: HMO insurances require a new referral each time you have an office visit, including follow up visits. You are responsible for requesting the referral from your primary care physician prior to your office visit.

Primary Insurance _____Copay $____ Secondary Insurance _____

Subscriber Name _____DOB _____ Subscriber Name _____DOB _____

Circle Relationship to Patient: Self / Spouse /Parent / Other Relationship: Self / Spouse / Parent / Other

Circle Address: Same / Other _____ Address: Same/Other _____

Patient Authorization: **1)** I authorize my insurance company to assign benefits to Digestive Disease Associates, LTD; and I agree to comply with the policies state in the above Insurance Information section. **2)** I authorize Digestive Disease Associates to release any information acquired in the course of my examination or treatment to my insurance company, my primary care physicians, and my approved contact. **3).** I confirm that I have received from Digestive Disease Associates the (1) Notice of Privacy Practices, (2) Patient's Bill of Rights and Responsibilities, and (3) Disclosure Information.

Signature: _____ **Date**: _____

Digestive Disease Associates, LTD.
Medical History Form

Disclaimer: Information gathered on this form will be transferred into your permanent electronic medical record (EMR). This form will be destroyed after the transfer has been made.

Patient Name:_____ **Male__ Female__ Date of Birth:**_____

Patient Medical History (please check and include date of onset):

- ☐ Anxiety Disorder
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Barrett's Esophagus
- ☐ BPH (enlarged prostate)
- ☐ Breast Cancer
- ☐ Cardiac Defibrillator
- ☐ Cardiac Pacemaker
- ☐ Celiac Disease (sprue)
- ☐ Cirrhosis Alcoholic
- ☐ Colon Cancer
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Crohn's Disease
- ☐ Deep Vein Thrombosis
- ☐ Depression
- ☐ Diabetes Type I (Insulin)
- ☐ Diabetes Type II (Non-Insulin)
- ☐ Diverticulitis
- ☐ Diverticulosis
- ☐ Elevated Triglycerides
- ☐ Elevated Cholesterol
- ☐ Emphysema
- ☐ GERD
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Hiatal Hernia
- ☐ Hypertension
- ☐ Hypothyroidism
- ☐ Irritable Bowel Syndrome
- ☐ Myocardial Infarction
- ☐ Peptic Ulcer Disease (ulcer)
- ☐ Transient Ischemic Attack
- ☐ Ulcerative Colitis
- ☐ Valve Disorders

Patient Surgical History (please check and include date of surgery):

- ☐ Abdominal Adhesions
- ☐ Appendectomy
- ☐ Arthroscopic Joint Surgery
- ☐ Blood Transfusion
- ☐ CABG (bypass surgery)
- ☐ Cataract Surgery
- ☐ Carotid Endartectomy
- ☐ Cholecystectomy (gallbladder removal)
- ☐ Colon Resection
- ☐ Colonoscopy/Flex Sig
- ☐ Coronary Angioplasty/ Coronary Stent Placement
- ☐ C-Section
- ☐ ERCP
- ☐ Upper Endoscopy
- ☐ Hernia Repair
- ☐ Hysterectomy
- ☐ Laparoscopy
- ☐ Thoracotomy
- ☐ Thyroidectomy
- ☐ TMJ Surgery
- ☐ Tonsillectomy
- ☐ Tubal Ligation
- ☐ TURP (prostate surgery)

Please advise us of any surgeries/testing that are not listed above:

1._____ 4._____

2._____ 5._____

3._____ 6._____

Patient Medications (please list all herbal, nutritional supplements, analgesics, vitamins, aspirin, blood thinners):

Medication	Dosage/Strength	Prescribing Physician	Reason for Taking Med
1.			
2.			
3.			
4.			
5.			
6.			

Patient Allergies (please include the reaction to the allergen):

Medications	Food	Environmental
1.	1.	1.
2.	2.	2.

Patient Family Medical History (please check and include age of onset if anyone in your immediate family has been diagnosed with):	Father	Mother	Brother	Sister
☐ Barrett's Esophagus				
☐ Celiac Disease				
☐ Cirrhosis (non-alcoholic)				
☐ Coronary Artery Disease				
☐ Crohn's Disease				
☐ Diabetes Mellitus - Type I (insulin)				
☐ Diabetes Mellitus - Type II (non-insulin)				
☐ Family History of Colon Cancer				
☐ Family History of Colon Polyps				
☐ Family History of Polyposis Coli				
☐ Hemachromatosis				
☐ Hepatitis B				
☐ Hepatitis C				
☐ Irritable Bowel Syndrome (IBS)				
☐ Ulcerative Colitis				
☐ Other Cancers				

Patient Social History:

Education Level:_____ Occupation:_____

Circle: Married / Single / Divorced / Widowed / Same Sex Relationship
Circle: Alcohol / Smoker / Other Substance Abuse / None

Review of Systems (please check if you are currently experiencing any of these symptoms):

Constitutional
- ☐ Fever
- ☐ Chills
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Fatigue
- ☐ Loss of Appetite

Eyes
- ☐ Change of Vision
- ☐ Blurred Vision
- ☐ Impaired Vision
- ☐ Double Vision
- ☐ Icterus (yellowish tint of
- ☐ the eye)

HENT
- ☐ Sore Throat
- ☐ Nasal Congestion
- ☐ Postnasal Drip
- ☐ Headaches
- ☐ Vertigo (dizziness)
- ☐ Lightheadedness
- ☐ Nose Bleeding
- ☐ Dentures
- ☐ Neck Stiffness
- ☐ Neck Pain
- ☐ Thyroid Mass
- ☐ Hearing Loss
- ☐ Oral Lesions

Breasts
- ☐ Lumps
- ☐ Tenderness

Cardiovascular
- ☐ Chest Pain
- ☐ Cardiac Murmurs
- ☐ Irregular Heart Beats
- ☐ Rapid Heart Rate
- ☐ Syncope (fainting)
- ☐ Dyspnea on exertion (shortness of breath with activity)
- ☐ Orthopena (shortness of breath while lying down)
- ☐ Lower extremity edema (swelling of the legs)
- ☐ Claudicating (cramping of legs with activity)
- ☐ Cyanosis (bluish tint to outer extremities)

Respiratory
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Cough
- ☐ Hoarseness
- ☐ Sleep Apnea
- ☐ Abnormal sputum production
- ☐ Hemoptysis(spitting up blood)
- ☐ Anesthetic problems
- ☐ TB exposure

Gastrointestinal
- ☐ Early Satiety (feeling full quickly)
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Hematemesis (vomiting blood)
- ☐ Dysphagia (difficulty swallowing)
- ☐ Odynophagia (pain with swallowing)
- ☐ Jaundice (yellowish tint to skin)
- ☐ Bloating
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal Pain
- ☐ Hemorrhoids
- ☐ Blood in Stools
- ☐ Melena (black tarry stools)
- ☐ Fatty Stools
- ☐ Mucous in Stools
- ☐ Narrow Stools

Genitourinary
- ☐ Urgency (of urination)
- ☐ Frequency (of urination)
- ☐ Decreased Stream
- ☐ Difficulty Voiding (urination)
- ☐ Incontinence
- ☐ Nocturia (night time urinating)
- ☐ Post-Void Dripping (dripping after urination)
- ☐ Dysuria (pain while urinating)
- ☐ Hematuria (blood in urine)
- ☐ Pneumaturia (air in urine)
- ☐ Irregular Menses
- ☐ Hot Flashes

Integument
- ☐ Rash
- ☐ Itching
- ☐ New Skin Lesions
- ☐ Changes to Existing Skin
- ☐ Pigmentation Changes

Neurologic
- ☐ Tingling or Numbness
- ☐ Muscular Weakness
- ☐ Incoordination
- ☐ Loss of Balance
- ☐ Headaches
- ☐ Difficulty Concentrating
- ☐ Memory Difficulties
- ☐ Speech Difficulties
- ☐ Tremors
- ☐ Seizures

Musculoskeletal
- ☐ Back Pain
- ☐ Bone Pain
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Limitation of Motion
- ☐ Muscle Pain
- ☐ Muscular Weakness
- ☐ Muscle Cramps

Endocrine
- ☐ Polyuria (frequent urination)
- ☐ Polydipsia (excessive thirst)
- ☐ Cold Intolerance
- ☐ Heat Intolerance

Heme-Lymph
- ☐ Easy Bleeding
- ☐ Easy Bruising
- ☐ Lymph Node Enlargement

Allergic-Immunologic
- ☐ Sinus Allergy Symptoms
- ☐ Allergic Dermatitis

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Feeling Confused
- ☐ Difficulty Sleeping
- ☐ Compulsive Behaviors
- ☐ Impulsive Behaviors
- ☐ Suicidal Ideation