



Naugatuck Valley
Gastroenterology
Consultants, LLC

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PATIENT INFORMATION

Patient's Name (Last, First and MI) _____

Address _____ City _____ State _____ Zip _____

Home Phone () _____ Mobile Phone () _____ Email _____

Date of Birth _____ Sex _____ Marital Status _____ SS# _____

Referring Physician _____ Last visit to Referring Physician _____ PCP _____

Employer Name _____ Phone () _____

INSURANCE INFORMATION

Primary Insurance Name _____ ID# _____

Policyholder Name _____ Relationship _____ Date of Birth _____

Secondary Insurance Name _____ ID# _____

Policyholder Name _____ Relationship _____ Date of Birth _____

SPOUSE/PARENT INFORMATION

Spouse/Parent _____ Date of Birth _____ SS# _____

Spouse/Parent Employer Name _____ Phone () _____

EMERGENCY CONTACT

Name _____ Relationship _____

Home Phone () _____ Mobile Phone () _____

PHARMACY INFORMATION

Pharmacy Name _____ Address _____ City _____

Phone () _____

NOTICE: PLEASE REMEMBER THAT INSURANCE IS CONSIDERED A METHOD OF REIMBURSEMENT AND IS NOT A GUARANTEE OF PAYMENT. SOME COMPANIES PAY FIXED ALLOWANCES FOR CERTAIN PROCEDURES, AND OTHERS PAY A PERCENTAGE OF THE CHARGES. IT IS YOUR RESPONSIBILITY TO PAY FOR ANY DEDUCTIBLES, CO-INSURANCE, CO-PAYS, OR ANY OTHER BALANCE NOT PAID BY YOUR INSURANCE. IF THIS ACCOUNT IS ASSIGNED TO AN ATTORNEY/COLLECTION AGENCY OR SUIT, THE PRACTICE IS ENTITLED TO REASONABLE ATTORNEY/COLLECTION FEES AND COURT COSTS. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS CONSIDERED TO BE VALID AS THE ORIGINAL. THE UNDERSIGNED UNDERSTANDS THAT THEY ARE FINANCIALLY RESPONSIBLE TO PAY FOR ALL CHARGES ACCORDING TO THEIR POLICIES AND PROVISIONS.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE PHYSICIAN OF ANY BENEFITS OTHERWISE PAYABLE TO ME FOR SERVICES REALIZING I AM RESPONSIBLE TO PAY FOR ANY NON COVERED SERVICES.

AUTHORIZATION TO RELEASE INFORMATION: I HEREBY AUTHORIZE MY PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY TREATMENT TO PROCESS INSURANCE CLAIMS.

I AGREE TO THE ASSIGNMENTS AND FINANCIAL RESPONSIBILITIES AS INDICATED ON THIS FORM.

Signature _____ **Date** _____

(THE CORPORATION RESERVES THE RIGHT TO DESIGNATE THE INDIVIDUAL TO PERFORM THE SERVICE ON ITS BEHALF)

MEDICAL HISTORY FORM

Name _____ Date of Birth _____ Age _____

Reason for today's visit _____

Height _____ Weight _____ Today's Date _____

YOUR MEDICAL HISTORY (please check off all that apply)

Have you had or currently have any heart problems (Stents, Pacemakers, Heart Attack) Yes No

Are you a diabetic? Yes No Insulin Pills

Are you being treated for High Blood Pressure? Yes No

Are you on any blood thinners (Coumadin, Warfarin, Plavix, Aggrenox, Pradaxa, etc.) Yes No

If yes who is your cardiologist? _____

Do you have any Kidney problems? Yes No

Are you allergic to eggs or soy? Yes No

Do you have or ever had Staph or a MRSA infection? Yes No

- Alcoholism/Drug Abuse Anemia Anxiety/Depression Arthritis
- Asthma/Emphysema Bleeding Tendency Bone Disease Cancer/Tumor
- Cirrhosis Colitis Crohn's Disease Diverticulosis/Diverticuliti
- Eating Disorders Epilepsy / Seizure Disorder Gallbladder Disease Gastroesophageal Reflux
- Glaucoma Gonorrhea/Syphilis/Herpes Heart Disease/Heart Failure Hemorrhoids
- HIV Infection / AIDS Irritable Bowel Syndrome Liver Disease Jaundice/Hepatitis
- Migraine Headaches Peptic Ulcer Disease Psychiatric Disease Prostate Disease/Cancer
- Stroke/TIA Thyroid Disease Tuberculosis Ulcerative Colitis
- Other _____

GASTROINTESTINAL

- Abdominal Pain Poor Appetite Bloody/black stools Chest Pain
- Constipation Cough/Hoarseness/Lump in throat Diarrhea
- Gas/Bloating Indigestion/Heartburn Nausea
- Pain/Difficulty Swallowing Rectal Pain Vomiting Weight Loss _____ lbs
(how much?)

OPERATIONS/SURGERY

- Appendix Colon/Small Intestine Gall Bladder Gastric Bypass/Lap band
- Hemorrhoids/Fissure Hysterectomy/Ovary Kidney Pacemaker/Defibrillator
- Stomach

If you checked off any item above, please list the dates of each item checked. For any surgery please list dates and where the surgery was performed: _____

TESTING (Have you ever had any of the following? Please check off all that apply.)

- Barium Swallow CT Abdomen/Pelvis MRI Abdomen/Pelvis HIDA Scan
- Ultrasound Upper GI Series Breath Testing Capsule Endoscopy
- Colonoscopy ERCP Liver Biopsy Upper Endoscopy

If you checked off any testing on the previous page, please list the dates and location where the testing was done:

Have you had any recent blood work / labs? Yes No

If yes, what kind and where was the blood work / labs done? _____

If yes, who ordered it & where was it done? _____

Have you had any stool testing / cultures? Yes No

If yes, what kind? _____

SOCIAL HISTORY

Do you or have you use(d) tobacco? Yes No

Do you or have you use(d) alcohol/drugs? Yes No

Do you drink caffeinated beverages? Yes No

Have you ever lived outside of the United States? Yes No Where _____ When _____

Have you received any blood transfusions? Yes No If yes was it before 1992? Yes No

What is your race?

American Indian or Alaska Native Asian African American White Native Hawaiian Other Pacific Islander More than one race No Response

What is your ethnicity? Hispanic or Latino Not Hispanic or Latino No Response

What is your preferred language? _____

Please list ALL ALLERGIES to medication or other substances: _____

Please list all of your current medications including alternative/herbal therapies with dosage, if you have a list we'll make a copy.

FAMILY HISTORY (Has anyone in your family had any of the following below?)

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Colon/Rectal Cancer | <input type="checkbox"/> Colon/Rectal Polyps |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Esophageal Cancer | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Liver Cancer |
| <input type="checkbox"/> Liver Disease/Hepatitis | <input type="checkbox"/> Ovarian Cancer | <input type="checkbox"/> Pancreatic Cancer | <input type="checkbox"/> Peptic Ulcer Disease |
| <input type="checkbox"/> Stomach Cancer | <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Uterine Cancer | |

Please list below who in your family had any of the items checks below and at what age if known:

Is there any other information you want the doctor to know or are there any questions you may want the doctor to answer?
