Patient Registration Form

Arizona Center for Digestive Health
www.azcdh.com

Patient Information

Name (First / Middle Initial / Last): _____ Date of Birth: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Other: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone: _____ Secondary Phone: _____

Email: _____ Gender: _____ Social Security #: _____

Referring Physician: _____ Primary Care Physician: _____

Preferred Language: _____ **Race:** ☐ White ☐ Black or African American ☐ Asian

☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander ☐ Uknown ☐ Patient Declines to Specify

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient Declines to Specify

Responsible Party:

☐ Self ☐ Other Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Emergency Contact

(This person will be contacted in the case of an emergency ONLY)

Name: _____ Relationship: _____ Phone: _____

Additional Information

Occupation: _____ Employer: _____

Insurance Information

Primary Insurance Company: _____ Relationship to Subscriber: _____ ID #: _____

Group #: _____ Network: _____ Claims Address: _____

Subscriber Name: _____ Birth Date: _____ Subscriber Social Security #: _____

Secondary Insurance Company: _____ Relationship to Subscriber: _____ ID #: _____

Group #: _____ Network: _____ Claims Address: _____

Subscriber Name: _____ Birth Date: _____ Subscriber Social Security #: _____

Pharmacy Information

Name: _____ Phone: _____

Cross Streets: _____ Address: _____

☐ I assign all medical/surgical benefits to Arizona Center for Digestive Health, P.L.L.C. and understand that I am financially responsible for all charges whether or not they are paid by insurance. I authorize payment to be made to the provider. In the event that the payment is made to the policyholder, I agree to submit payment in full to this office immediately.

☐ I hereby authorize the doctor to release or procure all information necessary to secure the payments of benefits, for treatment purposes, or to another health care provider or destination at my discretion. I may revoke this authorization at any time in writing, with the exception of insurance disclosures for billing purposes. I consent to communicate via electronic means for routine matters. I further agree that a photocopy of this agreement shall be as valid as the original. I certify the above information is true and correct to the best of my knowledge. I understand that HIPAA and privacy policies are available online and in the office by request.

☐ I have read and understand the information on this form.

☐ I confirm that the information I have provided here is correct and true to the best of my knowledge.

Signature: _____ Date: _____

Patient Interview Form

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Patient Information

First Name: _____ Last Name: _____ DOB: _____ Today's Date: _____

Email Address: _____ Sex: ☐ Female ☐ Male ☐ Other

Reminder Preference

Would you like to receive preventative care and follow up reminders? ☐ Yes ☐ No

Allergies

☐ Patient has no known allergies ☐ Patient has no known drug allergies

☐ Latex ☐ Penicillins ☐ Demerol ☐ Fentanyl ☐ Versed

☐ Iodine ☐ Propofol ☐ Sulfa ☐ Eggs ☐ Other: _____

Past or Present Medical Conditions

☐ Patient has no known medical conditions

NEUROLOGY
- ☐ Stroke
- ☐ Seizures/Epilepsy
- ☐ Dementia
- ☐ Parkinson's

ENDOCRINE
- ☐ Thyroid Disorder
- ☐ Diabetes
- ☐ Osteoperosis
- ☐ Elevated Cholesterol

CARDIAC
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Atrial Fibrillation
- ☐ Congestive Heart Failure

LUNGS
- ☐ Asthma
- ☐ COPD
- ☐ Valley Fever
- ☐ Sleep Apnea

URINARY
- ☐ Enlarged Prostate
- ☐ Prostate Cancer
- ☐ Kidney Stones
- ☐ Kidney Cancer

RHEUMATOLOGY
- ☐ Fibromyalgia
- ☐ Lupus
- ☐ Rheumatoid Arthritis

PSYCHIATRIC
- ☐ Anxiety Disorder
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Schizophrenia

CIRCULATION
- ☐ Deep Vein Thrombosis
- ☐ Carotid Artery Disease
- ☐ Pulmonary Embolus
- ☐ Peripheral Vascular Disease

BLOOD
- ☐ Anemia
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Bleeding Disorder

GASTROINTESTINAL
- ☐ Colon Polyps
- ☐ Diverticulosis
- ☐ Pancreatitis
- ☐ Barrett's Esophagus
- ☐ GERD
- ☐ Cirrhosis
- ☐ Irritable Bowel Syndrome
- ☐ Stomach Ulcer
- ☐ Ulcerative Colitis
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Colon Cancer
- ☐ H. pylori
- ☐ Lactose Intolerance
- ☐ Crohn's Disease
- ☐ Celiac Sprue

☐ **CANCER** Type: _____

CONDITIONS NOT LISTED: _____

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Diagnostic Studies/Tests

☐ None

☐ Colonoscopy ☐ Upper Endoscopy ☐ ERCP ☐ EUS

When: _____ When: _____ When: _____ When: _____

☐ Ultrasound ☐ CT Scan ☐ MRI ☐ Liver biopsy ☐ Recent labs

When: _____ When: _____ When: _____ When: _____ When: _____

Previous Procedures & Surgeries

☐ None

☐ Cataract surgery ☐ Tonsillectomy ☐ Thyroid surgery ☐ Heart valve ☐ Pacemaker

☐ Defibrillator ☐ Appendectomy ☐ Gallbladder removal ☐ Carotid artery ☐ Abdominal aneurysm

☐ C-section ☐ Hysterectomy ☐ Tubal ligation ☐ Breast surgery ☐ Prostate surgery

☐ Joint surgery ☐ Bowel surgery ☐ Hemorrhoids ☐ Coronary bypass ☐ Coronary artery stent

☐ Other: _____

Social History

Occupation: _____ Number of Children: _____

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

☐ Civil Union ☐ Other: _____

Alcohol

☐ None Quantity Number Frequency

☐ Beer _____

☐ Wine _____

☐ Hard Liquor _____

Tobacco/Smoking Status

☐ Current, Every Day Smoker ☐ Current, Some Day Smoker ☐ Former Smoker

☐ Smoker, Status Unknown ☐ Unknown if ever smoked ☐ Never Smoked

Drug Use

☐ None Quantity Number Frequency

☐ IV Drugs _____

☐ Other: _____

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Exercise Quantity Number Frequency

☐ None

Family Medical History

	Mother	Father	Sister	Brother	Daughter	Son	Grandmother	Grandfather	Aunt	Uncle
Colon cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Colon polyps	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Celiac disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ulcerative colitis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Crohn's disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Liver disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

☐ No knowledge of family history

☐ No family history of: ☐ Colon Cancer ☐ Polyps

Current Medications

☐ Patient has no known medications

Name	Dose	How Taken?

Consent to Import Medication History

I consent to Arizona Center for Digestive Health obtaining a history of my medications purchased at pharmacies.

☐ Yes ☐ No

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Review of Systems (Please Select All Recent Symptoms)

	Yes	No
CARDIOVASCULAR		
Chest pain	☐	☐
Shortness of breath with exercise	☐	☐
Palpitations	☐	☐
CONSTITUTIONAL		
Loss of appetite	☐	☐
Weight gain	☐	☐
Weight loss	☐	☐
ENMT		
Sore throat	☐	☐
Nose bleeds	☐	☐
Hoarseness	☐	☐
ENDOCRINE		
Excessive thirst	☐	☐
Hair loss	☐	☐
Heat intolerance	☐	☐
GASTROINTESTINAL		
Abdominal pain	☐	☐
Abdominal bloating	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Difficulty swallowing	☐	☐
Gas	☐	☐
Heartburn	☐	☐
Nausea	☐	☐
Rectal bleeding	☐	☐
Vomiting	☐	☐

	Yes	No
GENITOURINARY		
Dark urine	☐	☐
Painful urination	☐	☐
Blood in urine	☐	☐
INTEGUMENTARY		
Yellowing of the skin	☐	☐
Rash	☐	☐
Tattoos	☐	☐
Piercings	☐	☐
MUSCULOSKELETAL		
Arthritis	☐	☐
Back pain	☐	☐
NEUROLOGICAL		
Dizziness	☐	☐
Frequent headaches	☐	☐
Numbness or tingling	☐	☐
PSYCHIATRIC		
Anxiety	☐	☐
Depression	☐	☐
RESPIRATORY		
Cough	☐	☐
Coughing up blood	☐	☐
Wheezing	☐	☐

Reviewed with

☐ Patient ☐ Parent ☐ Guardian ☐ Not Present

HIPAA Privacy Acknowledgment

Arizona Center for Digestive Health
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- I have received the HIPAA Privacy Notice regarding the uses and disclosures of my Protected Health Information and I understand my rights and responsibilities with respect to my medical records.
- I hereby authorize Arizona Center for Digestive Health, PLLC to release any medical or incidental information to my referring physician or any other physicians who have been or may become involved in my care.
- I also authorize the release of information that may be necessary in the processing of any insurance claims.
- I also authorize the release of any medical records including pharmacy records to Arizona Center for Digestive Health, PLLC upon request.

PERSONAL REPRESENTATIVES

(Family members, attorneys, etc.): I hereby authorize Arizona Center for Digestive Health, PLLC and its Employees permission to discuss, send and/or receive medical information to/with the following individuals:

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

☐ **Decline** (I do not authorize permission to discuss, send and/or receive medical information to/with others.)

FAXES

When expedient, I authorize the transmittal of my records by FAX. I understand that transmission by FAX, but its very nature, is not confidential.

MESSAGES

It is OK to leave a message on my home phone voice mail #: _____ ☐ Yes ☐ No

It is OK to leave a message on my cell phone voice mail #: _____ ☐ Yes ☐ No

It is OK to leave a message on my work phone voice mail #: _____ ☐ Yes ☐ No

Patient Name (Please Print): _____ Date of Birth: _____

Patient Signature: _____ Date: _____