CENTRAL FLORIDA GASTROENTEROLOGY

PATIENT INFORMATION - INFORMACIÓN DEL PACIENTE

PATIENT NAME NOMBRE DEL PACIENTE				BIRTHDATE FECHA DE NACIMIENTO	SEX SEXO
ADDRESS DIRECCIÓN	CITY CIUDAD	STATE ESTADO	ZIP CODE ZIP CODE	SOCIAL SECURITY NUMBER NUMERO DE SEGURO SOCIAL	MARITAL STATUS ESTADO CIVIL ☐ SINGLE ☐ SOLTERO(A) ☐ MARRIED ☐ CASADO(A) ☐ DIVORCED ☐ DIVORCIADO(A) ☐ WIDOWED ☐ VIUDO(A)
HOME PHONE TELEFONO DE CASA	CELL PHONE TELEFONO CELULAR	EMAIL EMAIL		REFERRING PHYSICIAN MEDICO REFERIDO	
EMPLOYER PHONE # TELEFONO DEL PATRÓN	EMPLOYER NAME & ADDRESS PATRÓN & DIRECCIÓN		ARE YOU DISABLED ESTÁ USTED INCAPACITADO ☐ YES ☐ NO	DATE OF DISABILITY FECHA DE INCAPACIDAD	
SPOUSE/GUARDIAN NOMBRE DEL ESPOSO(A) / NOMBRE DEL CUSTIDIO		EMPLOYER PATRON		EMPLOYER PHONE # TELEFONO DEL PATRÓN	
EMERGENCY CONTACT CONTACTO DE EMERGENCIA		ADDRESS DIRECCIÓN		PHONE TELEFONO	

FOR REPORT PURPOSES ONLY: RACE _____ **ETHNICITY** _____ **LANGUAGE** _____

PRIMARY INSURANCE INFORMATION - INFORMACIÓN PRIMARIA DEL SEGURO

NAME OF INSURANCE COMPANY NOMBRE DE COMPANIA DE SEGURO		ADDRESS DIRECCIÓN		PHONE TELEFONO
EFFECTIVE DATE FECHA VIGENTE	PATIENT'S INS. ID # SEGURO DEL PACIENTE ID #	GROUP NAME NOMBRE DEL GRUPO	GROUP NUMBER NUMERO DE GRUPO	
NAME OF SUBSCRIBER NOMBRE DEL SUSCRIPTOR	SOCIAL SECURITY NUMBER OF SUBSCRIBER NUMERO DE SEGURO SOCIAL DEL SUSCRIPTOR	BIRTHDATE OF SUBSCRIBER FECHA DE NACIMIENTO DEL SUSCRIPTOR	RELATIONSHIP OF SUBSCRIBER TO PATIENT RELACIÓN DEL SUSCRIPTOR AL PACIENTE	

SECONDARY INSURANCE INFORMATION - INFORMACIÓN DE SEGURO SECUNDARIO

NAME OF INSURANCE COMPANY NOMBRE DE COMPANIA DE SEGURO		ADDRESS DIRECCIÓN		PHONE TELEFONO
EFFECTIVE DATE FECHA VIGENTE	PATIENT'S INS. ID # SEGURO DEL PACIENTE ID #	GROUP NAME NOMBRE DEL GRUPO	GROUP NUMBER NUMERO DE GRUPO	
NAME OF SUBSCRIBER NOMBRE DEL SUSCRIPTOR	SOCIAL SECURITY NUMBER OF SUBSCRIBER NUMERO DE SEGURO SOCIAL DEL SUSCRIPTOR	BIRTHDATE OF SUBSCRIBER FECHA DE NACIMIENTO DEL SUSCRIPTOR	RELATIONSHIP OF SUBSCRIBER TO PATIENT RELACIÓN DEL SUSCRIPTOR AL PACIENTE	

LIFETIME AUTHORIZATIONF FOR INSURANCE ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE - AUTORIZACION POR VIDA PARA ASIGNACION DE BENEFICIOS Y LIBERACION DE INFORMACION:

I hereby give consent to **Internal Medicine Specialists** to provide whatever treatment they deem necessary to the patient named above. I authorize any insurance company, organization, employer, hospital, physician, dentist or pharmacist to release any information requested with regard to obtain authorization for future treatment and with regard to processing claims.

I certify the information I furnish is true and correct and that I know it is a crime to fill out this form with facts that I know are false or to leave out facts that I know are important.

I assign payment directly to the physicians, nurse practitioners, or physician assistants at **Internal Medicine Specialists** which may be due to me from the Medicare program or other health insurance company. I understand I am financially responsible to **Internal Medicine Specialists** for any non-covered insurance services.

Patient or Responsible Party:_____Date:_____

All necessary lab work will be billed separately by an independent laboratory. Please notify nurse of special laboratory requirements.

Por este medico doy mi concentimiento a **Internal Medicine Specialists** para proveer cualquier tratamiento que ellos estimen necesario al paciente en referencia. Autorizo cualquier compania de seguro, organizacion, patrono, hospital, medico, dentista o farmaceutico a liberar cualquier informacion requerida para obtener autorizacion para futuro tratamiento y processamiento de reclamos.

Yo certifico que la informacion que esloy dando es cierta y correcta y que estoy conceinte que es una violacion de ley proveer informacion falsa y/o de informar informacion intencionalmente sabiendo que es importante.

Yo assigno pago directo a los medicos, enfermeras practicante (nurse practitioners) y/o assistentes medicos en **Internal Medicine Specialists** que puedan estar debiendome del programa de medicare o cualiquier otra compania de serguro. Yo entiendo que soy responsible por cualquier deuda financiera a **Internal Medicine Specialists** por todo servicio no cubierto por servicios de seguro.

Paciente o persona responsible_____ Fecha _____

Todo trabajo de laboratorio sera facturado por separado por el laboratorio independiente. Favor de notificarle a la enfermera se cualquier requerimiento especial de laboratorio.

COMMERCIAL INSURANCE - SEGURO COMERCIAL

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the doctor or group indicated on the claim. I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

Payment is requested at time of service for self pay patients. A bookkeeper can assist you if arrangements must be made. We will be glad to assist with insurance forms. Your policy and coverage is a contract between you and your insurance company. You are responsible for all payments.

Yo autorizo que se ofresca la información necesaria para asi someter un reclamo con mi compañia de seguro y qué los beneficios sean asignados a mi o de otro modo a mi doctor o el grupo indicado en la forma del seguro. Yo tengo entendido que yo soy responsable por cualquier balance que mi seguro no cubra. Una copia de esta firma es valida como la original.

El pago es requerido al tiempo que se rinden los servicios a todo paciente no asegurado. Alguien de nuestro departamento de seguro puede asistirle si necesita un arreglo de pagos mensuales. Nosotros podemos asistirle en llenar las formas para su seguro. Su poliza de seguro es un contrato entre usted y la compañia de seguro. Usted es responsable de los pagos.

Signature / Firma_____ Date/ Fecha_____

Witness / Testigo_____ Date/ Fecha_____

FOR OFFICE USE ONLY CHART #: INITIALS: PERCENT NEEDED? ☐ YES ☐ NO COPAY: AUTHORIZATION NUMBER:

109300 (1/11)

CENTRAL FLORIDA GASTROENTEROLOGY
a division of internal medicine specialists

Circle all that apply (add any additional please)

Patient Name: _____ Today's date: _____

Reason for visit today:

_____

Medications:
Please bring everything you take (prescription *and* over the counter medications) in their bottles please.

Allergies to medications:

_____

Previous Tests (when, where and results):
Colonoscopy _____

Gastroscopy _____

CT Abdomen/Pelvis _____

Ultrasound _____

Liver Biopsy _____

GI Medical Problems (circle all that apply):
Polyps, Cancer of the _____, GERD, Rectal Bleeding, Liver Disease, Colitis (UC / Crohn's / other), Celiac Disease, Lupus, Scleroderma, Pancreatitis, Nausea, Diarrhea, Constipation, Weight loss, Anemia, alcohol abuse, Barrett's Esophagus, Schatzki Ring, Other(s): _____

Other Medical Problems (circle all that apply):
Have you ever received chemotherapy, radiation therapy or other treatments for any condition? Yes / No

High Blood Pressure, Diabetes, High Cholesterol, Angina, heart attack, heart murmur, Anemia, Arthritis, Asthma, Atrial Fibrillation, BPH, COPD, Epilepsy, Glaucoma, Macular Degeneration, Sickle Cell, Gout, Cancer of the _____, Bladder problems, BPH (Prostate enlarged), Heart Problems, Liver Problems, Anemia, Pulmonary Problems, Environmental Allergies, Other(s): _____

complete front and back

(BACK)

Surgeries (circle all that apply):
Gallbladder, Hysterectomy (total or partial), C-Section (# _____), Appendectomy, Open Heart (# bypass _____ , valve replacement, pacemaker), Gastric Bypass, Cataract, Hemorrhoidectomy, Hip Replacement, Hernia Repair, Back Surgery, Knee (Replacement, Arthroscopy), Breast (Mastectomy, Lumpectomy), TURP, Plastic Surgery, other(s) _____

Family History (circle all that apply):
Any family history of colon cancer, stomach cancer, polyps or GI diseases: yes / no. List :_____

Father: alive/deceased Health Problems / Cause of Death: _____
Mother: alive/deceased Health Problems / Cause of Death _____
Sisters/Brothers: Brothers _____ Sisters _____ Are they healthy? Yes / No
Children: Sons _____ Daughters _____ Are they healthy? Yes / No

Social History (circle all that apply):
Have you ever received a blood transfusion? Yes / No When? _____

Marital Status: Married / Divorced / Single / Widowed / Separated / Life Partner / Other
Occupation: _____
Tobacco: ____ ppd for _____ years / None / Quit after _____ years of _____ppd
Alcohol: _____ Caffeine: _____ cups of coffee, cola or tea per day
Recreational Drugs: never / current / past: IV drugs / Cocaine / marijuana / others

Review of Systems: (circle all that apply)

Allergy: Itchy eyes, runny nose, scratchy throat, sinus congestion

General: Fatigue

Dermatology: mole, rash, hives

Ophthalmology: blurred vision, eye irritation

ENT, Respiratory: shortness of breath, nose bleeds, vocal changes, cough

Cardiology: chest pain, leg edema, palpitations

Gastroenterology: Abdominal pain, rectal bleeding, change in bowel habits, weight loss, nausea, vomiting, heartburn, difficulty swallowing, painful swallowing, constipation, diarrhea, vomiting blood, black tarry stools, rectal pain, gas, incontinence, feeling full early in a meal, anorexia, fever, jaundice

Urology: blood in urine, difficulty urinating, frequent urination

Neurology: headache, insomnia, seizures

Psychology: memory loss, considering suicide, depression, anxiety, sleep disturbances

Musculoskeletal: joint pain, leg cramps, gout

Endocrinology: heat intolerance, frequent urination, excessive thirst, excessive sweating

Hematology: bleeding or bruising, anemia, past transfusion