Central Florida Gastroenterology

Patient Information Sheet:

This page provides our office with important information such as your insurance carrier, emergency contact and allows us to have permission to bill your insurance company. Please complete this form with current information. Please include your Email address, this will give you access to your medical information electronically. You will initially get an email with a user ID and password and be directed to a website, you will be able to log on to the patient portal portal and access your medical information. You will also be able to email your doctor's nurse. Please fill out these forms in their entirety. All forms are relevant to your medical care.

Consent and Acknowledgement forms:

These are known as HIPAA forms (Health Insurance and Portability and Accountability Act). They give us your consent to use or disclose your patient information for treatment, payment, or health care operations. We do not sell or trade your personal information. Please include either a spouse or family member in which we are allowed to speak with. If you do not have one please mark N/A, do not leave blank.

Insurance Cards:

Please remember to bring a picture ID and your insurance card(s) to your appointment. If your spouse, parent, or significant other is the primary cardholder, you will be required to provide their date of birth in order to file a claim. Otherwise, you may be required to pay at time of service.

Initial consultation:

This first visit allows us to get a better understanding of your health problems. The doctor will decide what will be the best course of action and whether or not you need a procedure done.

CENTRAL FLORIDA GASTROENTEROLOGY

PATIENT INFORMATION - INFORMACION DEL PACIENTE

PATIENT NAME / NOMBRE DEL PACIENTE				BIRTHDATE / FECHA DE NACIMIENTO	SEX / SEXO
ADDRESS / DIRECCION	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 / PATRON & DIRECCION			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 / DIRECCION			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 / DIRECCION		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 / DIRECCION		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 estoy 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 cualquier 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 así 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)

NEPHROLOGY CONSULTANTS
CENTRAL FLORIDA GASTROENTEROLOGY
a division of internal medicine specialists
3885 Oakwater Circle • Orlando, FL 32806 • 407-851-5600 • Fax: 407-438-9561

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

The Patient hereby consents to the use or disclosure of his/her individually identifiable health information ("protected health information") and patient medical record information by **Internal Medicine Specialists, Inc.** (the "Practice") in order to carry out treatment, payment, or health care operations. The Patient should review the Practice's Notice of Privacy Practices for a more complete description of the potential uses and disclosures of such information, and the Patient has the right to review such Notice prior to signing this Consent Form.

The Practice reserves for itself the right to change the terms of its Notice of Privacy Practices at any time. If the Practice does change the terms of its Notice of Privacy Practices, Patient may obtain a copy of the revised Notice.

Patient retains the right to request that the Practice further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Practice is not required to agree to such requested restrictions; however, if the Practice does agree to Patient's requested restriction(s), such restrictions are then binding on the Practice.

Patient acknowledges and agrees that the Practice may disclose Patient's protected health information and patient medical record information to the following individuals who are either the Patient's family members, legal representatives, guardian, health care surrogates, or have power of attorney on behalf of the Patient: **(Patient must fill out) Name/Relationship:** ______________________________

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The Patient agrees that the Practice may disclose the following types of information contained in the Patient's medical records (please **initial, do not check,** the appropriate categories listed below):

	Restrictions		Restrictions
________ HIV/AIDS Information	________________	________ Mental Health Information	________________
________ Substance Abuse Information	________________	________ If Patient is under the age of eighteen (18), Pregnancy information	________________
________ Sexually Transmitted Disease Information	________________		

Patient agrees and consents to the Practice releasing information to Patient in the following alternative manners (please **initial, do not** check the appropriate spaces below):

________ Via e-mail to the Patient's designated e-mail address which is: ______________________________.

________ Via Regular Mail with any envelopes being marked personal and confidential and addressed to Patient.

________ Via telephone, if Patient contacts the Practice and provides the appropriate information (including the Patient's name, social security number and date of birth.)

At all times, Patient retains the right to revoke this Consent. Such revocation must be submitted to the Practice in writing. The revocation shall be effective *except* to the extent that the Practice has already taken action in reliance on the Consent. If you revoke this consent, Internal Medicine Specialists will only continue to treat you on an emergency basis, and in that case for 30 days.

The Practice may refuse to treat Patient if he/she (or an authorized representative) does not sign this Consent Form. If Patient (or authorized representative) signs this Consent and then revokes it, the Practice has the right to refuse to provide further treatment to Patient as of the time of revocation (except to the extent that the Practice is required by law to treat individuals).

I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I MAY RECEIVE A COPY OF THIS CONSENT, AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS SEALED DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

Date:______________ Time:____________ AM / PM

______________________________ ______________________________

Signature of Patient/Authorized Representative* Please Print Name

*Please explain Representative's Relationship to Patient and include a description of Representative's Authority to act on behalf of the Patient. Please attach proof of guardianship with a court document.

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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 / others), 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