Southwest Gastroenterology Associates, PLLC

PLEASE PRINT Date:

Patient Information

Patient's Name _____ **Birth Date** _____ **Age** _____
Last First Middle

Child ( ) **Single ( )** **Married ( )** **Divorced ( )** **Widowed ( )** **Separated ( )**

Home Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone _____ **Cell Phone** _____

Social Security No _____ **Email** _____

Employer _____ **Employer Phone** _____

Name of Spouse (Parent – if minor) _____ **Birth Date** _____

Cell Phone _____ **Social Security No** _____

Employer _____ **Telephone** _____

Insurance Information

Primary Insurance Company _____

Telephone _____ Policy/Medicare No. _____ Group No. _____

Subscriber _____ Date of Birth _____

Secondary Insurance Company _____

Telephone _____ Policy/Medicare No. _____ Group No. _____

Subscriber _____ Date of Birth _____

Meaningful Use

What is meaningful use? Electronic health records can provide many benefits for providers and their patients, but the benefits depend on how they're used. Meaningful use is the set of standards defined by the Centers for Medicare & Medicaid Services (CMS) Incentive Programs that governs the use of electronic health records and allows eligible providers and hospitals to earn incentive payments by meeting specific criteria. For details about the incentive programs visit the CMS website.

The following questions are part of these requirements:

Race: _____ American Indian _____ Asian _____ Black/African American _____ White
_____ Hispanic/Latino _____ Hawaiian _____ Multi-racial _____ Greek _____ Other

Primary Language: ____English _____Spanish _____Arabic _____Chinese _____French ____German ____Hebrew ____Hindi
____Italian _____Japanese _____Korean ____Vietnamese

Ethnicity: _____ Hispanic/Latino _____Not Hispanic/Latino

Insurance Authorization and Assignment

I hereby authorize Southwest Gastroenterology Associates, PLLC to furnish information to insurance carriers concerning my treatment and I hereby assign to the doctor all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. I also release any medical institutions to furnish copies of my medical records to Southwest Gastroenterology Associates, PLLC.

Patient's signature _____

A photocopy of this authorization shall be considered as valid as the original.

Emergency Contact (other than spouse) Name _____

Relationship _____ Telephone _____

Referred By _____ Primary Care Physician _____

Patient's Communication Preferences and Consent to use PHI

Patient Name: _____ Patient's Date of Birth: _____

Telephone Communication Preferences:

Home # _____ Work # _____ Mobile # _____

E-Mail Communication Preferences

Email Address _____

In order to best serve our patients and communicate regarding their services and financial obligations we will use all methods of communication provided to expedite those needs. By providing the information above I agree that Southwest Gastroenterology Associates, PLLC or one of its legal agents may use the telephone numbers provided to send me a text notification, call using a pre-recorded/artificial voice message through the use of an automated dialing service or leave a voice message on an answering device. If an email address has been provided, Southwest Gastroenterology Associates, PLLC or one of its legal agents may contact me with an email notification regarding my care, our services, or my financial obligation.

Mail Communication Preferences

May we send mail to your home address? ***(If no, please provide an alternate)***

_____

_____

Other than you, your insurance company, and health care providers involved in your care, whom can we talk with about your health care information? (Check all that apply)

	Name:	Telephone
☐ Spouse	_____	_____
☐ Caretaker	_____	_____
☐ Child	_____	_____
☐ Parent	_____	_____
☐ Other	_____	_____

Do you have any health information that you would like to be kept confidential from any person or persons? If so, please specifically describe the information and person or persons below:

_____

_____

I understand that and agree to the following:
1) As part of my health care, Southwest Gastroenterology Associates, PLLC, originates and maintains health records describing by health history, symptom, examinations and test results, diagnoses, treatment and any plans for future care.
2) This agreement shall apply to all information accumulated up to this date and to any information acquired in the future.
3) I have been offered a copy of the **Privacy Notice** that provides a more complete description of information uses and disclosures.
4) I have the right to review the **Privacy Notice** prior to signing this consent and that Southwest Gastroenterology Associates, PLLC reserves the right to change their notice and practices, but that prior to implementation will mail a copy of any revised notice to the address I have provided.
5) I have a right to object to the use of my health information for directory purposes.
6) I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Southwest Gastroenterology Associates, PLLC, is not required to agree to the restrictions requested.
7) I have the right to revoke this consent in writing, except to the extent the organization has already taken action in reliance thereon.

This agreement to release information shall remain in force until such time as I shall revoke it in writing.

By Oklahoma Law we are required to notify you that the information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, as known as Acquired Immune Deficiency syndrome (AIDS).

I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information.

I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information.

_____ _____

Patient or Personal Representative Signature **Date**

_____ _____

Printed Name **Relationship to Patient**

Southwest Gastroenterology Associates, PLLC
525 SW 80th Street
Suite 200
Oklahoma City, OK 73139
Phone: (405) 631.0481 Fax: (405) 551.8447

Consent to Obtain Electronic Medical History

I understand that my medication history may be obtained utilizing an electronic information exchange and that this protected health information may provide valuable information for my healthcare provider.

I hereby authorize, Southwest Gastroenterology Associates, PLLC to access my medication history without limitation or exclusion as is requited and / or reasonably advisable to disclose, process, retrieve, transmit, and view for the purpose of the transmission of an electronic prescription issued by a provider authorized by law to prescribe, as necessary for my care and treatment.

_____

Pharmacy Name and Phone Number

_____

Pharmacy Location

_____

Preferred Lab

_____

Patient's Name

_____

Patient's Signature Date

Southwest Gastroenterology Associates, PLLC
525 SW 80th Street Suite 200
Oklahoma City, OK 73139
Phone (405) 631-0481 Fax (405) 551-8447

General Payment Agreement

In seeking medical care, you have obligated yourself to compensate the provider for his/her services, regardless of your medical insurance or expectation of payment by some other third party. You are expected to pay for your visit in full at each visit unless you are a member of a plan in which the provider is contracted. We will file a claim on your behalf with your insurance plan. You are responsible for any deductible and/or co-payment at the time services are rendered. If you are unsure of your co-payment amount, you will be responsible for 20% of the total.

I authorize SWGA to contact me via current and any future cellular phone number(s), email address(es) or wireless device(s) regarding my delinquent account(s) or debt I owe to SWGA or to receive general information from SWGA. I also authorize SWGA and its agents, representatives, and attorneys (including collection agencies) to use automated telephone dialing equipment, artificial or pre-recorded voice or text messages, and personal calls and emails in their effort to contact me for purposes of collecting any portion of my account financial obligation which is past due. Furthermore, I understand I may withdraw my consent to call my cellular phone by submitting my request in writing to SWGA or its agents on behalf of SWGA.

Usual and Customary Fees

You are responsible for the full amount of your bill, regardless of your insurance company's "Usual and Customary" fee allowance, unless it is an insurance plan in which our providers are contracted.

Responsible Party

The "Responsible Party" is the person to whom we look to for payment. The patient is always the responsible party unless the patient is a minor or has a legal guardian.

Appointments

We recognize that your time is valuable. We will make every effort to see you as close to your appointment time as possible. We do not guarantee appointment times. Should you not be able to keep an appointment, please notify us 24 hours in advance.

I have read this agreement and understand my responsibilities:

Patient's printed name: _____

Patient's signature: _____

Date: _____

SOUTHWEST GASTROENTEROLOGY ASSOCIATES, PLLC

Medical History Questionnaire

Name: _____
First Middle Last

Date:	Sex:	Age:	Religion:

Describe Problems You Wish to Discuss Today:

1. _____
2. _____
3. _____

Please Print

Check Known Allergies or Reactions to Medications, List any shown.

Allergies to medications: Yes____ No____ List: _____

List Medications Taken over the last six months:

Medication/Drug	Dosage (mg)	Frequency

Medical Equipment used daily: ____CPAP ___Oxygen (O2) ___Other: _____

Which drugs do you take:

___ Aspirin
___ Ibuprofen/Motrin
___ Birth Control Pills
___ Hormones
___ Laxatives
___ Antacids
___ Vitamins
___ Supplements
___ Aleve/Naproxen
___ Other:_____
___ Other:_____

Review of Systems

General
___ Chills
___ Fever
___ Malaise/feeling tired
___ Weight Loss
___ Other _____

HEENT
__ Double Vision
___ Ear Infections
___ Eye Pain
___ Nasal Congestion
___ Sinus Infection
___ Sore Throat
___ Other _____

Lungs
___Dyspnea/Difficulty breathing
___ Frequent Cough
___ Pleuritic/Chest Pain
___ Other _____

Heart
___ Chest Pain
___ Extremity Edema/Swelling in legs
___ Palpitations/irregular heart rhythm
___ Other _____

Gastrointestinal
___ Abdominal pain
___ Change in bowel habits
___ Constipation
___ Diarrhea
___ Dysphagia/Difficulty Swallowing
___ Heartburn
___ Hematemesis/vomiting blood
___ Loss of Appetite
___ Melena/Black Stools
___ Nausea
___ Reflux
___ Vomiting
___ Other _____

Genitourinary
___ Dysuria/painful urination
___ Hematuria/Blood in urine
___ Urinary Frequency
___ Urinary Incontinence/leaking of urine
___ Urinary retention
___ Other _____

Reproductive
___ Penile discharge
___ Sexual dysfunction
___ Other_____

Metabolic/Endocrine
___ Nervous
___ Dizziness
___ Numbness
___ Tremors
___ Vertigo
___ Anxiety
___ Depression
___ Increased stress
___ Other _____

Skin
___ Contact allergy
___ Hives
___ Pruritus
___ Rash
___ Other _____

Musculoskeletal
___ Back Pain
___ Myalagia/muscle pain
___ Joint Pain

Hematologic
___ Easy Bleeding
___ Easy Bruising
___ Lymphadenopathy
___ Other _____

Past Medical History

___ Alcoholism	___ Cerebrovascular Accident/Stroke	___ Migraine Headaches
___ Anemia/Low blood counts	___ Diabetes Mellitus	___ Obesity
___ Arthritis	___ Diverticular Disease	___ Obstructive Sleep Apnea
___ Asthma	___ Exposure to hepatitis	___ Pancreatitis
___ Blood Transfusion	___ GERD	___ Parkinson's disease
___ Celiac Disease	___ Gout	___ Peptic ulcer disease
___ Cholelithiasis/Gall Stones	___ Hemochromatosis-Hereditary	___ Prostate cancer
___ Chronic renal failure	___ Hepatitis	___ Prostate Hyperplasia, benign
___ Cirrhosis	___ Hyperlipidemia/High Cholesterol	___ Seizure disorder
___ Colon cancer	___ Hypertension	___ Thyroid Disease
___ Colon Polyps	___ Irritable bowel syndrome	___ Ulcerative Colitis
___ Congestive heart failure	___ Kidney disease	___ Varices - esophageal
___ COPD/Emphysema	___ Kidney stones	___ Varices - gastric
___ Coronary Artery Disease/Hrt Attack	___ Liver cancer	
___ Crohn's Disease	___ Liver disease	

Past Surgical History

	Year		Year		Year
___ Angioplasty	_____	___ Colonoscopy	_____	___ Small Bowel Resection	_____
___ Angio w/Stent	_____	___ EGD	_____	___ Thyroidectomy	_____
___ Appendectomy	_____	___ Gastric Bypass	_____	___ Bilateral Tubal Ligation	_____
___ Back Surgery	_____	___ Hernia Repair	_____	___ Cesarean Section	_____
___ CABS	_____	___ Hip replacement	_____	___ Hysterectomy	_____
___ Carpal Tunnel Release	_____	___ Knee replacement	_____	___ Mastectomy	_____
___ Cholecystectomy-Gall Bladder	_____	___ Liver Biopsy	_____	___ TAH/BSO	_____
___ Colectomy	_____	___ ORIF	_____	___ Vaginal Hysterectomy	_____
		___ Pacemaker	_____		

Additional History

System:_____ Disease:_____ Year:_____

Management:_____ Year:_____ Outcome:_____

Family History

	Family Member (ie: Father)	Age at Diagnosis
Colon Cancer		
Stomach Cancer		
Esophageal Cancer		
Liver Cancer		
Pancreatic Cancer		

Social History

Tobacco

Current____ Former___ (year quit _____) Never___

Cigarettes_____ Cigar_____ Pipe____ Chew ____

Packs per day _____ # of years smoking _____

Interested in quitting? Yes___ No ___

Caffeine # per day / week (circle one)

Soda _____

Coffee _____

Occupation

_____ Retired? Yes___ No ___

Alcohol

Beer/Wine _____ Liquor _____

# of drinks per _____ day / week / year (circle one)

Name _____ Date _____