Digestive Diseases CENTER

PATIENT REGISTRATION AND CONSENT FORM

Last Name_____ First Name_____ MI_____
Social Security _____ Date of Birth_____ Male / Female
Mailing Address_____
Street City State Zip
Race_____ Marital Status_____
Home Phone_____ Cell Phone_____
Email Address: _____
Primary Care Doctor_____ Referring Doctor_____
Employer: _____ Work Phone _____
Emergency Contact_____ Phone_____

Primary Insurance_____
Policy_____ Group_____
Address_____City_____ State_____ Zip_____
Policy Holder _____
Date of Birth _____ Social Security _____Relationship_____

Secondary Insurance_____
Policy_____ Group_____
Address_____ City_____ State _____ Zip_____
Policy Holder_____
Date of Birth _____ Social Security _____Relationship_____

My signature below authorizes **Digestive Diseases Center** to release any medical information necessary to process me or my dependent's insurance claim. I authorize any benefits due to be paid directly to **Digestive Diseases Center**. By providing the above contact information to the **Digestive Diseases Center** (DDC), I authorize the DDC and persons acting on the DDC's behalf to bill and collect for services rendered to contact me via email messages, phone calls and text messages at the email address and phone numbers provided, including telephone calls using an automatic telephone dialing system and /or an artificial or prerecorded voice. I represent and agree I am the subscriber or customary user with respect to the email address and telephone numbers provided and have the authority to give this consent. I further agree to notify the DDC of any changes to the email address and telephone numbers provided. I agree to indemnify the DDC and persons acting on their behalf, its directors, officers, employees and agents, and hold them harmless, from and against any and all loses, claims, damages, liabilities, costs or expenses (including any attorneys' fees) that arise out of my breach of any of the foregoing representations and agreements. Your insurance company only provides our office an "estimate" of covered benefits prior to receiving any services or materials from us. This "estimate" is not a guarantee of benefits. I understand that I may be required to pay a deductible, co-pay, co-insurance, or any balance not covered by insurance plan. In the event that my insurance does not fully pay for services and/or materials rendered to me, I agree to be responsible for payment of all balances on my or my dependent's behalf.

I understand that all fees for professional services shall be paid at time of service. Unsettled balances may be referred to an outside collection agency and credit bureau. Returned checks will be subject to additional fees.
I certify that I have read the above information to the best of my knowledge.

_____ _____
Patient or Guarantor Signature **Date Signed**

10/09/19LW

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT OF RECEIPT

I, _____, acknowledge receipt of Digestive Diseases Center's Notice of Privacy Practices which was effective April 14, 2003.

Patient Signature: _____ Date Signed: _____

Patient Printed Name: _____

I AUTHORIZE THE RELEASE OF MY MEDICAL AND/OR BILLING INFORMATION TO THE FOLLOWING INDIVIUALS:

1. _____ Relationship to Patient _____

2. _____ Relationship to Patient _____

3. _____ Relationship to Patient _____

****

FOR OFFICE USE ONLY

We were unable to obtain a written acknowledgment of receipt of the Notice of Privacy Practices because:

____ An emergency existed and a signature was not possible at the time

____ The Individual refused to sign

____A copy was mailed with a request for a signature by return mail

____ Unable to communicate with the patient for the following reason:

_____

_____

____ Other _____

Staff Signature: _____ Date: _____

THIS RELEASE OF INFORMATION WILL REMAIN IN EFFECT UNTIL TERMINATED BY ME IN WRITING.

Digestive Diseases CENTER

Name: _____ **Date:** _____ **Age:** _____
Referring Dr: _____ **Chart#** _____ **Physician:** _____

What are the primary symptoms you are here to discuss? _____

Describe the symptoms _____

How long have you been experiencing these symptoms? _____

Severity of Symptoms: (circle one) **Mild** **Moderate** **Severe**

- Frequency of Symptoms (for example, daily, weekly, etc.) _____

Does anything make symptoms better? _____

- Worse? _____

What is your preferred pharmacy? _____ Location: _____

MEDICAL HISTORY

Have you had the following vaccines within the last year?

Pneumonia Vaccine ☐Yes ☐No **Flu Shot** ☐Yes ☐NO **Covid Vaccine** ☐Yes ☐NO

Have you ever been diagnosed					
Asthma	☐ Yes ☐ No	Enlarged Prostate (BPH)	☐ Yes ☐ No	Anemia	☐ Yes ☐ No
COPD/Emphysema	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Cirrhosis	☐ Yes ☐ No
Pulmonary embolism/DVT (blood clot)	☐ Yes ☐ No	Stroke (CVA)	☐ Yes ☐ No	Hepatitis B	☐ Yes ☐ No
Sleep Apnea	☐ Yes ☐ No	TIA	☐ Yes ☐ No	Hepatitis C	☐ Yes ☐ No
Congestive Heart Failure	☐ Yes ☐ No	Anxiety/Depression	☐ Yes ☐ No	Colon Polyps	☐ Yes ☐ No
Coronary Artery Disease	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Irritable Bowel Syndrome	☐ Yes ☐ No
Heart Attack (myocardial infarction)	☐ Yes ☐ No	Epilepsy/Seizures	☐ Yes ☐ No	Celiac Disease	☐ Yes ☐ No
Atrial Fibrillation	☐ Yes ☐ No	Lupus	☐ Yes ☐ No	Crohn's Disease	☐ Yes ☐ No
High Cholesterol	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No	Ulcerative Colitis	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Acid Reflux	☐ Yes ☐ No
Chronic Kidney Disease ESRD/ Dialysis	☐ Yes ☐ No	HIV/AIDS	☐ Yes ☐ No	Endometriosis	☐ Yes ☐ No
Kidney Stones	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No	PCOS	☐ Yes ☐ No

Cancer ☐ Yes ☐ No If yes what type: _____

Other Medical Problems: _____

SURGICAL HISTORY

Appendectomy	☐ Yes ☐ No	Hemorrhoidectomy	☐ Yes ☐ No	Knee replacement	☐ Yes ☐ No
Cholecystectomy	☐ Yes ☐ No	Small intestine removed	☐ Yes ☐ No	Aortic Aneurysm Repair	☐ Yes ☐ No
C-Section	☐ Yes ☐ No	Thyroidectomy	☐ Yes ☐ No	Defibrillator Placement	☐ Yes ☐ No
Hysterectomy	☐ Yes ☐ No	Tonsillectomy	☐ Yes ☐ No	Pacemaker Placement	☐ Yes ☐ No
Ovaries Removed	☐ Yes ☐ No	Hernia repair	☐ Yes ☐ No	Heart Bypass (CABG)	☐ Yes ☐ No
Tubal Ligation	☐ Yes ☐ No	Nissen Fundoplication	☐ Yes ☐ No	Heart Stent Placement	☐ Yes ☐ No
Colonoscopy/Endoscopy	☐ Yes ☐ No	Prostate Surgery	☐ Yes ☐ No	Heart Valve Replacement	☐ Yes ☐ No
Colon resection	☐ Yes ☐ No	Hip fracture repair/ replacement	☐ Yes ☐ No	Lumbar/Cervical Spinal Surgery	☐ Yes ☐ No
Gastric Bypass/Lap Band/Gastric Sleeve	☐ Yes ☐ No				☐ Yes ☐ No

Other Surgeries: _____

FAMILY MEDICAL HISTORY

Type	Relation
Colon Cancer	
Colon Polyps	
Stomach Cancer	
Crohn's/ Ulcerative Colitis	
Celiac	
Ovarian Cancer	
Uterine Cancer	
Pancreatic Cancer	

Other Cancer: ☐ Yes ☐ No (specify) _____

SOCIAL HISTORY

Do you currently smoke cigarettes? ☐ **Yes** ☐ **No** If so, how many years have you smoked? _____
How many packs per day? _____
If you smoked cigarettes previously but quit, approximately what year did you quit? _____
Do you use smokeless tobacco? ☐ **Yes** ☐ **No** Vape? ☐ **Yes** ☐ **No** Marijuana use? ☐ **Yes** ☐ **No**
On average, how many alcoholic beverages do you consume per week? _____
Have you ever used intravenous (IV) drugs recreationally? ☐ **Yes** ☐ **No**
Are you? **MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED ☐**
What is your occupation? _____

HAVE YOU RECENTLY EXPERIENCED ANY OF THESE SYMPTOMS?

Fever	☐ Yes ☐ No	Chest pain	☐ Yes ☐ No	Unintentional Wt Loss	☐ Yes ☐ No
Shortness of Breath	☐ Yes ☐ No				

CURRENT MEDICATIONS (please list or provide list)
___ Rx, Over the counter & supplement _____

ALLERGIES: _____

Nurses Only HT: _____ **WT:** _____ **BP:** _____

Digestive Diseases CENTER

204 East 19th Street~ Panama City, FL 32405
Phone number 850-763-5409 Fax 850-763-7129

Digestive Diseases Center Patient Policies

We place a strong emphasis on patient-physician communication and will listen to you and answer your questions. Our office staff wants to help you. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

On arrival, please check in at the front desk if paperwork is needed you will be asked to fill it out at that time.

1. Please be sure we have the correct insurance information on file. If you fail to provide us the proper insurance within 60 days of your office visit you will be responsible for the office visit.
2. It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists, if preauthorization is required prior to a procedure, and what services are covered.
3. You are responsible for any and all co-payments, deductibles, and coinsurances at the time of your visit.
4. YOU ARE RESPONSIBLE FOR ANY BALANCE ON YOUR ACCOUNT.
5. If you have no insurance, payment for an office visit is to be paid at the time of the visit.
6. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Please pay your balances promptly.
7. If previous arrangements have not been made with our finance office any balances over 120 days will be forwarded to a collection agency.
8. It is your responsibility to know if a selected specialist participates in your plan.
9. Not all services provided by our office are covered by every plan, any service determined to not be covered by your plan will be your responsibility.
10. Please note that the labs and other results are reviewed only during an office visit. Anytime you have a test completed: please make sure you have an appointment to go over the results. If you for some reason do not show up for an appointment and have abnormal results, it will not be the office responsibility to review those labs or to contact you regarding them.
11. **YOU WILL BE CHARGED A $50 FEE <u>IF YOU NO SHOW</u> FOR ANY PROCEDURES SCHEDULED.**

I have read and understand these office patient policies and agree to comply and accept the responsibility for any payment that becomes due, as out lined previously.

Patient Name _____

Patient Signature _____ Date_____