DOUGLAS JAY SPRUNG MD., FACG., FACP.

The Gastroenterology Group

Date: _____

NAME: _____ **AGE**:_____ **DOB:** ___/___/___

Why are you here to see the doctor today? _____

_____

_____

REFERRED BY:

- ☐ INSURANCE
- ☐ HEALTHGRADES
- ☐ INTERNET
- ☐ FRIENDS/RELATIVES _____
- ☐ PCP _____
- ☐ OTHER _____

Medications you are allergic to: _____

_____

Food Intolerances: _____

_____

Specify any foreign travel in the last 6 months:

_____

Do you smoke?

- ☐ Yes
- ☐ No
- ☐ Previously - When did you Quit? _____

Do you drink alcoholic beverages?

- ☐ Yes Amount? _____
- ☐ No

Do you drink coffee?

- ☐ Yes
- ☐ No

Are you on Aspirin? ☐ Yes ☐ No

Do you take any blood thinners? ☐ Yes ☐ No

Do you have stents? ☐ Yes ☐ No

Do you have artificial joints? ☐ Yes ☐ No

If yes, which and when?

_____

_____

_____

Prior GI Tests:

	Dates
☐ Colonoscopy	_____
☐ EGD	_____
☐ CT ABDOMEN/PELVIS	_____
☐ U/S ABDOMEN	_____
☐ OTHERS	_____

FAMILY HISTORY

Please list if paternal/maternal relation

Disease	Family Member
☐ Colon Polyps	_____
☐ Colon Cancer	_____
☐ Gallbladder Disease	_____
☐ Other Cancers: Which?	_____
☐ Heart Attacks	_____
☐ Heart Failure	_____
☐ Stroke	_____
☐ Diabetes	_____
☐ Other:	_____

SURGERY AND HOSPITALIZATIONS REVIEW:

List all Hospitalizations, Operations and Injuries in the last 10 years

YEAR	REASON	HOSPITAL

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Patient Name: _____ **Date:** _____

MEDICATION LIST

PRESCRIPTIONS		
MEDICATION	DOSAGE OR STRENGTH	TIMES TAKEN DAILY

OVER THE COUNTER MEDICATIONS / VITAMINS / SUPPLEMENTS / HERBS		

PAST MEDICAL HISTORY: Place an (X) in the box in front of a past problem.

	Hypertension		Jaundice		Genital Herpes		Anemia
	Heart Attacks		Cancer (_____)		Nervous Disorders		Arthritis
	Heart Failure		Asthma		Epilepsy		Phlebitis
	Angina		Emphysema		Depression		Diabetes
	Ulcers Gastric/Duodenal		Rheumatic Fever		Glaucoma		Kidney Stones
	Tuberculosis		Stroke		Urinary Tract Infections		Colitis
	Liver Disease		Syphilis		Colitis		Hepatitis
	Gonorrhea		Pneumonia		Colon Polyps		Colon Cancer

SYSTEM REVIEW: Place an (X) in the box in front of the past problems.

	Poor Appetite		Nose Bleeds		Difficulty Swallowing
	Weight Loss		Hoarseness		Heartburn
	Weight Gain		Sinus Trouble		Indigestion
	Thyroid Disease		Ear Infections		Vomiting
	Fatigue		Frequent Cough		Nausea
	Weakness		Wheezing		Stomach Pain
	Fever/Chills		Sputum		Diarrhea
	Poor Concentration		Shortness of Breath		Constipation
	Poor Memory		Cough up Blood		Blood in Stools
	Headaches		Tuberculosis Exposure		Vomiting Blood
	Convulsions		Palpitations		Bloating
	Loss of Consciousness		Heart Murmur		Belching
	Paralysis		Enlarged Heart		Flatulence (Gas)
	Numbness		Ankle Swelling		Rectal Pain
	Backaches		Chest Pain		Mucus in Stools
	Muscle Weakness		Leg Cramps		Hemorrhoids
	Muscle Pain		Varicose Veins		Change in Bowel Habits
	Muscle Spasms		Gout		HIV
	AIDS				

AUTHORIZATION TO RELEASE OR USE INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

I hereby authorize the release or use of my protected health information ("PHI") and medical record information by The Gastroenterology Group (the "Practice") in order to carry out treatment, payment, or health care operations. These disclosures may be by phone, mail, fax or electronic transmission. You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

If you allow a third party other than our practice physician or staff to be in the exam room while our physician or staff is examining your or discussing your care, treatment or medical condition with you, by signing this Consent form you are consenting to the disclosure of your PHI to that third party.

We reserve the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised Notice.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or health care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

I acknowledge and agree that the Practice may disclose my protected health information and medical record information to the following individuals: (please initial line and write in name of individual)

_____ Spouse _____ _____ Parent _____

_____ Child _____ _____ Legal Guardian _____

_____ Other _____ _____ Other _____

I agree that the Practice may also disclose the following types of information contained in my medical record (please initial the appropriate categories listed below):

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

I agree and consent to the Practice releasing information to me in the following alternative manner(s) (please initial the appropriate spaces below):

_____ Via mail & telephone _____ Via email address _____

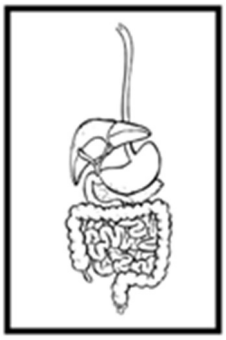
_____ Text

At all times, you retain the right to revoke the 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 based on the prior Consent. **The Practice may refuse to treat you if you (or an authorized representative) do not sign this Consent Form.** If you (or authorized representative) sign this Consent and then revoke it, the Practice has the right to refuse to provide further treatment to you 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 am the patient or the authorized party to act on behalf of the patient to sign this document verifying consent to the above terms. By signing below, I acknowledge and agree to the above conditions.

Date: _____ Signature of Patient/authorized representative _____

Print Name _____



The Gastroenterology Group

ACKNOWLEDGEMENT FORM

Our notice of Privacy Practices provides information about how we may use and release protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by writing our practice or requesting a copy from our front desk staff.

You have the right to request that we restrict how protected health information about you is used or released for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and release of protected health information about you for treatment, payment and health care operations as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made releases in reliance on your prior consent.

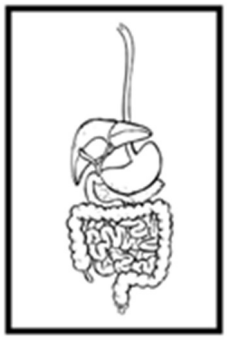
Patient Name

(Print) _____

(Signature) _____

Date: _____

Witness: _____



The Gastroenterology Group

I UNDERSTAND THAT IF I DO NOT SHOW, RESCHEDULE, OR CANCEL MY APPOINTMENT WITHOUT 24 HOURS NOTICE, I WILL BE RESPONSIBLE FOR A CHARGE OF $40.00. IN ADDITION, IF I AM 15 MINUTES OR MORE LATE I WILL BE MARKED AS A NO SHOW.

_____

Print Name

_____

Patient Signature

_____

Date

Updated 03/12/2019

The Gastroenterology Group

PATIENT INFORMATION SHEET FOR MEDICAL RECORDS

(PLEASE PRINT)

SS#: _____-_____-_____

Full Legal Name: _____ Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ DOB: _____

Sex: ☐ **Male** ☐ **Female**

Employed By: _____ Work Phone: _____ Ext: _____

Marital Status: ☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Widow**

Spouse's Full Legal Name:_____ DOB: _____

Spouse's Cell: _____ Work Phone: _____ Ext:_____

If Patient is a Minor

Who is responsible for the bill: _____Relationship: _____

Address of Responsible Party: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Home Phone: _____ Cell: _____

Signature _____ Date: _____