

ADVANCED CARE GASTROENTEROLOGY ASSOCIATES

Patient Registration Form

Date of Appointment: _____

Patient Information

Patient's First Name		Middle Name	Last Name <small>(as it appears on insurance card or ID)</small>		
Sex	Marital Status	Date of Birth (Age)		Social Security Number	
Patient's Address			City	State	Zip
Home Phone		Mobile Phone		Email Address	
Referred by		Primary Care Physician		Primary Care Physician Phone	
Pharmacy	Pharmacy Phone		Pharmacy Address		

Patient Employer/School Information

Employer/School		Occupation	Employer/School Phone		
Employer/School Address			City	State	Zip

Emergency Contact Information

Emergency Contact Name		Emergency Contact Phone	Relation to Patient
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Billing and Insurance

Primary Health Insurance

Insurance Company		Plan			
Plan Number	Group Number	Insured's Employer/School			
Insured's Name <small>(as it appears on insurance card or ID)</small>		Relation to Patient		Insured's Phone Number	
Insured's Address		City	State	Zip	
Insured's Social Security Number	Insured's Birthdate				

Secondary Health Insurance

Insurance Company		Plan			
Plan Number	Group Number	Insured's Employer/School		Insured's Social Security Number	
Insured's Name <small>(as it appears on insurance card or ID)</small>		Relation to Patient		Insured's Phone Number	

Responsible Party

Billing Name <small>(if other than patient)</small>		Phone	Relation to Patient		
Address		City	State	Zip	

Signature of Patient or Authorized Guardian

Date

ADVANCED CARE GASTROENTEROLOGY ASSOCIATES

Name: _____ Age: _____ Gender: _____ Date of Appointment: _____

Reason for Visit

What brings you to the office today?

Have you ever had any of the following Gastroenterological symptoms?
(Please check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Gluten Intolerance |
| <input type="checkbox"/> Anal Pain | <input type="checkbox"/> Heartburn/Acid Reflux |
| <input type="checkbox"/> Bleeding (Black, Red, or Maroon Stool) | <input type="checkbox"/> Jaundice (Yellow Skin, Dark Urine) |
| <input type="checkbox"/> Change in Appetite | <input type="checkbox"/> Lactose Intolerance |
| <input type="checkbox"/> Change in Bowel Habits | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Pain when swallowing |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Weight Gain |
| <input type="checkbox"/> Excessive Gassiness | <input type="checkbox"/> Weight Loss |

Past Medical History

- | | |
|--|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Hepatitis C |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hiatal Hernia |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Irritable Bowel |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Joint Disorder |
| <input type="checkbox"/> AIDS / HIV | <input type="checkbox"/> Kidney Disorder |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Liver Disorder |
| <input type="checkbox"/> Blood Disorder (including clots) | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Cancer Type: _____ | <input type="checkbox"/> Mouth Ulcer |
| <input type="checkbox"/> Celiac Disease | <input type="checkbox"/> Obesity Surgery |
| <input type="checkbox"/> Colon Cancer Polyps | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Parasites |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Sexually Transmitted Infection |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Skin Disorder |
| <input type="checkbox"/> Duodenal Ulcer | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Ear Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Frequent Urinary Tract Infections | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Groin Hernia | <input type="checkbox"/> Ulcerative Colitis |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Hemorrhoids | _____ |

Medications

What medications are you currently taking? (Include aspirin, blood thinners, vitamins, minerals, herbals, supplements, laxatives)

_____ Name	_____ Dosage	_____ Frequency
_____ Name	_____ Dosage	_____ Frequency
_____ Name	_____ Dosage	_____ Frequency
_____ Name	_____ Dosage	_____ Frequency

Allergies

Are you allergic to any of the following?

- | | | |
|---|--|--|
| <input type="checkbox"/> ACE Inhibitors | <input type="checkbox"/> Fentanyl | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Adhesive Tape | <input type="checkbox"/> Iodine (including contrast dye) | <input type="checkbox"/> Seizure Medicines |
| <input type="checkbox"/> Anesthetics | <input type="checkbox"/> Latex | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Midazolam (Versed) | <input type="checkbox"/> Valium |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> NSAIDs (Ibuprofen, Naprosyn, Advil) | |

Reactions: _____

Family History

Has anyone in your family ever had any of the following conditions?

- | | |
|---|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Joint Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Celiac Disease | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Colon Polyps | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Crohn's Disease/Ulcerative Colitis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Gall Bladder Disease | <input type="checkbox"/> None of the Above |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Not Sure |
| <input type="checkbox"/> High Blood Pressure | |

Details: _____

Women Only

Number of Pregnancies: _____

Number of Miscarriages: _____

Number of Abortions: _____

Number of Living Children: _____

Check if you have had any of the following:

- | | | |
|--|--|------------------------------------|
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Ovarian Cyst(s) | <input type="checkbox"/> Menopause |
| <input type="checkbox"/> C/Section | <input type="checkbox"/> Tubal Ligation | |

Birth Control: Yes No If yes, type: _____

Hospitalizations & Surgeries

_____ Reason	_____ Date
_____ Reason	_____ Date
_____ Reason	_____ Date
_____ Reason	_____ Date

ADVANCED CARE GASTROENTEROLOGY ASSOCIATES

Name: _____ Age: _____ Gender: _____ Date of Appointment: _____

Previous Gastroenterological Procedures and Tests

- | | Month & Year |
|---|--------------|
| <input type="checkbox"/> Colonoscopy | _____ |
| <input type="checkbox"/> Sigmoidoscopy | _____ |
| <input type="checkbox"/> Upper Endoscopy (EGD) | _____ |
| <input type="checkbox"/> Video Capsule Studies (Pill Cam) | _____ |
| <input type="checkbox"/> Upper Gastroenterological Series | _____ |
| <input type="checkbox"/> Sonogram | _____ |
| <input type="checkbox"/> Barium Enema | _____ |

Lifestyle Factors

- Are you sexually active?
 Yes No # of partners in past year _____
- Do you wish to be checked for Sexually Transmitted Infections?
 Yes No
- Have you ever smoked?
 Yes No # of years _____ # packs/day _____
- Do you smoke now?
 Yes No # packs/day _____
- Do you use recreational drugs?
 Yes No What type? _____ # times/week _____
- How much alcohol do you drink per week?
drinks/week _____
- How much caffeine do you drink per day?
drinks/day _____
- How often do you exercise?
times/week _____
- Have you traveled or lived outside the US or Canada?
 Yes No

Immunizations

Please check and date all immunizations you have had.

- | | Month & Year |
|--|--------------|
| <input type="checkbox"/> Flu Vaccine | _____ |
| <input type="checkbox"/> Hepatitis A | _____ |
| <input type="checkbox"/> Hepatitis B (Series of 3) | _____ |
| <input type="checkbox"/> Pneumovax | _____ |
| <input type="checkbox"/> Rotavirus | _____ |
| <input type="checkbox"/> Shingles (Zoster) | _____ |

Review of Systems

General

- Cold Intolerance
- Fatigue
- Fevers

Eye

- Change in Vision
- Eye Pain

Mood

- Anxiety
- Depression
- Difficulty Concentrating
- Poor Sleep
- Suicidal Thoughts

Genitourinary

- Blood in Urine
- Change in Sexual Function
- Difficulty Urinating

Neurologic

- Headache
- Poor Balance
- Tingling in Hands/Feet

Heart and Circulation

- Chest Pains
- Palpitations
- Swelling in Legs

ENT

- Changes in Voice
- Hearing Loss
- Nose-Bleeds
- Sore Throat

Muscles/Bones

- Joint Pain
- Muscle Pain
- Muscle Weakness

Respiratory

- Cough
- Shortness of Breath
- Wheezing

Skin

- Discoloration
- Hair Loss
- Hives
- Rash

Other Symptoms

Advanced Care Gastroenterology Associates

15303 Amberly Drive, suite A
Tampa, FL 33647
Phone: 813-751-9727
Fax: 813-441-7373
info@advancedcaregastro.com

Authorization for Release of Medical Records

I hereby authorize _____ to disclose the

Insert Primary Care Physician and/or doctor's office information here

following health record information for the purposes of continuation of

medical care to Dr. Sobia Ali:

Patient Name: _____

Date of Birth: _____ Phone #: _____

History & Physical Exam

Last Progress Note

Discharge Summary

Laboratory Reports

ER Physician Notes / Labs

Operative Reports

Endoscopy (EGD) / Colonoscopy

Insurance Verification

Pathology Reports

X-Ray / MRI / CT Scans

Other: _____

Patient Signature: _____ Date: _____

Sobia Ali, MD

Advanced Care Gastroenterology Associates

Advanced Care Gastroenterology Associates

15303 Amberly Drive, Suite A
Tampa, FL 33647
Phone: 813-751-9727
Fax: 813-441-7373
info@advancedcaregastro.com

Authorization for Billing of Services

I understand that payment of all medical care is due at the time of service. The parent and/or legal guardian who signs this form is responsible for any and all co-pays, deductibles, co-insurance, and/or unpaid balances not covered by insurance, regardless of marital status. It is also the patient's responsibility to obtain referrals from your primary care physician when required. I understand that I am responsible for any costs incurred in the collection of a patient's account in case of default, including reasonable attorney fees and court costs.

I have fully read and understand the above statement of payment policy. I hereby request any benefits on my behalf be paid to the physicians. I also authorize the release of any information acquired in the course of my treatment to my insurance company as needed to issue benefits. I authorize the physicians to administer such treatment as they may deem advisable for my diagnosis and treatment. I certify that I have been made aware of the role and services offered by the physician and I consent to care by such providers. I understand that these services are voluntary and that I have the right to refuse these services.

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

Patient Signature: _____ **Date:** _____

Medicare Patients Only

I request that payment of authorized Medigap (Medicare Supplement) benefits be made on my behalf to the provider for any services furnished to me by the provider. I authorize the release of any medical information about me needed by my Medigap Insurer to determine those benefits payable for related services.

Patient Signature: _____ **Date:** _____

Acknowledgement Notice & Consent of Privacy Practices

By signing this document, I acknowledge that there is a copy of the Notice of Privacy Practices for Advanced Care Gastroenterology Associates available to me. I am also giving my written consent for use and disclosure of my personal health information as described in the Notice of Privacy Practices. I understand that I have the right to revoke this consent at any time by giving written notice. Should you have any questions, concerns, or complaints, you may contact the Privacy Officer: Krysten Blouin, Medical Assistant.

I authorize Advanced Care Gastroenterology, LLC (Sobia Ali, MD) to disclose my health information to the following persons:

<u>Name</u>	<u>Phone Number</u>
_____	_____
_____	_____
_____	_____
_____	_____

Patient Signature: _____ **Date:** _____