Auburn Gastroenterology, LLC

PATIENT REGISTRATION

Date: _____

Patient Name _____

Sex ☐ M ☐ F Marital Status _____

DoB _____ SS# _____

Address _____

City _____ State _____ Zip _____

Home Phone (___) _____

Cell Phone (___) _____

Employer _____

Occupation _____

Work Phone (___) _____

Spouse Name _____

DoB _____ SS# _____

Address (if other than yours) _____

_____

City _____ State _____ Zip _____

Home Phone (___) _____

Employer _____

Occupation _____

Work Phone (___) _____

Responsible for Payment ☐ Self ☐ Spouse ☐ Other _____

Address (if other than yours) _____ City _____ State _____ Zip _____

Home Phone (___) _____ Work Phone (___) _____ SS# _____

Emergency Contact Person _____ **Relationship** _____ **Phone** (___) _____

Referred By _____

Insurance Information

Primary _____ Address _____

Policy No. _____ Group No. _____

Name of Insured _____ Relationship _____ DoB ___/___/___

Secondary _____ Address _____

Policy No. _____ Group No. _____

Name of Insured _____ Relationship _____ DoB ___/___/___

Medicare/Medicaid/Other _____ Current Card No. _____

Authorization of Treatment and Assignment of Benefit

I authorize Auburn Gastroenterology, LLC to treat me. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to Auburn Gastroenterology, LLC for all medical and surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original.

I understand that if my physician(s), or any person employed by or under the direction and control of my physician(s), is directly exposed to my body fluids in any manner which may, according to the current guidelines for the Center for Disease Control, transmit the human immunodeficiency virus (HIV) or hepatitis B or C viruses, that I am deemed by law to have consented to testing for infection with HIV or hepatitis B or C viruses. I further understand that by law I will have deemed to have consented to the release of these test results to the person who is exposed to my body fluids.

Patient Signature _____ Date _____

Witness _____ Date _____

Do You Have Any Advance Directive? (Living Will, And/Or Durable Power of Attorney for Healthcare) ☐ **Yes** ☐ **No**

Auburn Gastroenterology
Medical History

Date: _____

Please answer the following questions:

Last Name _____ First Name _____ Middle Initial _____.
Date of birth _____/_____/_____ Present Age _____ Height _____ Weight _____

Preferred Pharmacy _____
Other Physicians you see _____
Reason for today's visit _____
_____
What was the year of your last colonoscopy? _____ What was the year of your last EGD? _____

Past Medical History (circle any conditions you have had):

Anemia	Gallbladder Disease	Liver Disease
Asthma	Gastric Ulcer	Mitral Valve Prolapse
Atrial Fibrillation	GERD	Neuropathy
Bleeding Disorder	Gout	Obstructive Sleep Apnea
Chest Pain	Heart Disease / CAD	Osteoarthritis
Chronic Headache	Hepatitis	Osteoporosis
Colitis, Ulcerative	Hernia	Peptic Ulcer Disease
COPD	HIV / AIDS	Renal / Kidney Disease
Dementia / Alzheimer's	Hyperlipidemia	Seizures
Depressive Disorder	Hypertension	Stroke / TIA
Diabetes I or II	Hypoglycemia	Cancer: type _____
Emphysema	Low Testosterone	_____

Other major diseases:
_____
_____
_____

Operations you have had: _____
_____
_____

List all medicines and supplements you take:

Medicine or Supplement	How much?	How often?	Physician

Are you allergic to any medicines? No ____ Yes ____. Please List: _____
Are you allergic to latex? No___ Yes ___. Have you had a reaction to local or general anesthesia? No ___ Yes ___.
Have you had a reaction to a blood transfusion? No ____ Yes ____. Are you on blood thinners? No ____ Yes _____

Please answer the following questions:

Habits

Do you smoke? No ____ Yes ____.
How many years have you smoked? _____
Do you use alcohol? No ____ Yes ____.
Have you used recreational drugs (cocaine, marijuana, etc.)? No ____ Yes ____
Use smokeless tobacco? No ____ Yes ____.
Packs per day? _____.
How often? _____.

Family History

Please mark any health problems in your blood relatives (parents, grandparents, brothers, sisters, children, aunts, and uncles).

Yes	No	Disease	Relative (s)	
____	____	**Cancer**	_____	**Type:** _____
____	____	**Diabetes**	_____	**Type:** _____
____	____	**Heart Disease**	_____	
____	____	**High Blood Pressure**	_____	
____	____	**Bleeding Disorder**	_____	
____	____	**Lung Disease**	_____	
____	____	**Kidney Disease**	_____	
____	____	**Stroke**	_____	
____	____	**Tuberculosis**	_____	
____	____	**Problems with general anesthesia**	_____	
____	____	**Other? Specify**	_____	

Symptoms

Please check any of these problems you have had in the past 6 month:

Constitutional	Fever, chills
Eyes	Change in vision, blurred vision
HENT	Sore throat, nasal congestion, nasal discharge, sinus pain, headaches
Breasts	Lumps/mass, tenderness, nipple discharge
Cardiovascular	Chest pain, cardiac murmers, irregular heartbeats, Shortness of breath on exertion
Respiratory	Shortness of breath, wheezing
Gastrointestinal	Nausea, constipation, vomiting, change in abdominal girth, diarrhea, blood in stools
Genitourinary	Urgency, nocutria, frequency, painful urination
Integument	Rash, itching, new skin lesions
Neurologic	Tingling or numbness, incoordination, seizures
Musculoskeletal	Bone pain, back pain, joint pain
Endocrine	Excessive urination, increased thirst, Weight gain, weight loss, heat intolerance, cold intolerance
Psychiatric	Anxiety, depression
Heme-Lymph	Easy bleeding, easy bruising, lymph node enlargement or tenderness
Allergic-Immunologic	Sinus allergy symptoms, frequent illness

Other problem(s)? _____
_____
_____