



PATIENT REGISTRATION

Patient's Name _____ Date _____

Street Address _____ City _____ State & Zip _____

Home Phone (____) _____ Sex _____ Age _____ Date of Birth _____

Cell Phone (____) _____ Email Address _____ Race _____

Primary Language _____ Employer _____ Occupation _____

Work Phone (____) _____ May we contact you at work? Y N

Referring Physician _____

Family Physician _____

Spouse's Name _____ Martial Status M S D W

Spouse's Occupation _____ Spouse's Birthday _____

FOR COMMERCIAL INSURANCES: I hereby authorize the insurance company(ies) listed to pay directly to The Center for GI Health for services furnished to me; otherwise, payable to me under terms of my insurance. I hereby authorize photocopies of this authorization to be considered valid and effective as the original.

Patients Signature _____ **Date** _____

LIFETIME MEDICARE AUTHORIZATION: I authorize any holder of medical or other information about me to release to the Social Security Administration & Health Care Financing Administration or its intermediaries or Carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original & request payment of authorized Medicare benefits to be made to Drs. Kucer, Markos, and Lukaszewski (The Center for GI Health). Regulations pertaining to Medicare assignment of benefits apply.

Patients Signature _____ **Date** _____

MEDIGAP: I request that payment of authorized Medigap benefits be made to either me or on my behalf to Drs. Kucer, Markos, and Lukaszewski (The Center for GI Health) for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to _____ any information needed to determine these benefits payable for related services.

Patients Signature _____ **Date** _____

Patient Name _____
 Patient DOB _____
 Date _____

Medical History

Please check if you have a **personal**
 or **family** history of the following:

Do you have any of the following
 symptoms?

		PERSONAL / FAMILY				Yes / No	
		<input type="checkbox"/>	<input type="checkbox"/>	<i>List family member</i>			
Abnormal Liver Tests	<input type="checkbox"/>	<input type="checkbox"/>	_____	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	
Anal Fissure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Poor Appetite	<input type="checkbox"/>	<input type="checkbox"/>	
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____	Bloating/Belching	<input type="checkbox"/>	<input type="checkbox"/>	
Arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>	_____	Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	
Atrial Fibrillation	<input type="checkbox"/>	<input type="checkbox"/>	_____	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	_____	Regurgitation	<input type="checkbox"/>	<input type="checkbox"/>	
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Change in Bowel Habits	<input type="checkbox"/>	<input type="checkbox"/>	
Colon Polyps	<input type="checkbox"/>	<input type="checkbox"/>	_____	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	
Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	
Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____	Black, Tarry Stools	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Rectal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	
Diverticulitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Recent Weight Change	<input type="checkbox"/>	<input type="checkbox"/>	
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____	Bleeding/Bruising	<input type="checkbox"/>	<input type="checkbox"/>	
Gall Stones	<input type="checkbox"/>	<input type="checkbox"/>	_____	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	
Gallbladder Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Fever	<input type="checkbox"/>	<input type="checkbox"/>	
Gastro Esophageal Reflux	<input type="checkbox"/>	<input type="checkbox"/>	_____	Blurred or Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Ear Ringing	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	_____	Mouth Sores	<input type="checkbox"/>	<input type="checkbox"/>	
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	_____	Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	_____	Swelling of Ankles	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cough	<input type="checkbox"/>	<input type="checkbox"/>	
Irritable Bowel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	_____	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	_____	Rash/Itching	<input type="checkbox"/>	<input type="checkbox"/>	
Pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____	Memory Loss	<input type="checkbox"/>	<input type="checkbox"/>	
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	_____	Confusion	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____	Feeling of Depression	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Feeling of Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	
Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>	
Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>	_____				

Patient Name _____

Patient DOB _____

Date _____

Other Personal Medical History _____

Other Family Medical History _____

List any surgeries you have had and the year of the surgery _____

During any surgical procedure, have you been told you have difficult intubation? _____

Have you been diagnosed with Cancer? If so, please list site and when you were diagnosed _____

Have you ever had an Upper Endoscopy? If so, what year? _____

Have you ever had a colonoscopy? If so, what year? _____

Have you ever had a flexible sigmoidoscopy? If so, what year? _____

Do you Have tattoos? _____ Have you ever been given a blood transfusion? _____

What is your daily caffeine intake? _____ Do you drink alcohol? _____

Do you smoke? _____ If no, have you ever? _____ Do you use IV/Street Drugs? _____

Signature _____ Date _____

THE BOXES BELOW ARE FOR OFFICE USE ONLY

Are there any changes to your medical history since your past visit? Y N
If so, what are they? _____
Signature _____ Date _____

Are there any changes to your medical history since your past visit? Y N
If so, what are they? _____
Signature _____ Date _____

Are there any changes to your medical history since your past visit? Y N
If so, what are they? _____
Signature _____ Date _____



PATIENT FINANCIAL RESPONSIBILITY

Health insurance coverage is a contract between you and your insurance company.

Patients should be aware of their benefit coverage PRIOR to receiving care.

If you are not familiar with your plan coverage, please contact your insurance company directly.

- Know your deductibles, co-pay and co-insurance amounts. Copay amounts are due at the time of service – this is a plan requirement you agreed to when enrolling in the plan.

- Referral and Authorization requirements.

- Covered and Non-Covered benefits – these include but are not limited to: Laboratory and Radiology services, Colonoscopy, Upper Endoscopy (EGD), Capsule Endoscopy, Hemorrhoid treatment, Fiberoptic Sigmoidoscopy, Office Visits.....

We will submit a claim to your insurance company on your behalf; however, if unpaid, the patient or responsible party is ultimately responsible for the charges. Your account may be turned over to a Collection Agency if any unpaid balances are not paid within 10 days of patient receiving delinquency letter.

PATIENT FINANCIAL ACKNOWLEDGEMENT:

I have read, understand and agree to the policy as stated above. I understand that regardless of my insurance claim status or absence of insurance coverage, I am responsible for the balance on my account for the care and services rendered.

Patient Name (please print)

(Signature)

(Date)