Patient Registration Form

Patient Name: _____ Preferred first name:_____

DOB: _____ ☐ Male ☐Female SSN:_____

Primary Address: _____

City: _____ State: _____ Zip: _____

Phone#: _____ Cell#: _____

Secondary Address: _____

City: _____ State: _____ Zip: _____

Alternate Phone#: _____ Type ☐Home ☐ Cell ☐Work

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Other ☐Declined

Nationality: ☐American Indian or Alaska Native ☐Asian ☐Black or African American
☐Native Hawaiian or Other Pacific Islander ☐ White ☐Other ☐Declined

Primary Language:_____

Preferred method(s) of contact: ☐Mail ☐Email ☐Home Phone ☐Cell Phone ☐Text ☐Online Portal

Personal Email:_____

Pharmacy Name/Location :_____ Pharmacy Phone: _____

Primary Care Physician:_____

Whom may we thank for referring you:_____

Employer Status: ☐Employed ☐Self-Employed ☐Retired ☐Disabled ☐Unemployed ☐Student

Occupation:_____Employer_____

Employer Address_____ Work Phone: _____

EMERGENCY CONTACTS

#1. Name: _____ Relationship: _____ Phone#: _____

#2. Name: _____ Relationship: _____ Phone#: _____

INSURANCE INFORMATION

Primary Insurance Carrier: _____ Eligibilty Phone#: _____

Policy holder ID: _____Group ID:_____

Policyholder's Name: _____ Date of Birth_____ Sex: ☐ Male ☐Female

Policyholder's SS#:: _____ Relationship to patient: _____

Secondary Insurance Carrier: _____ Eligibilty Phone#: _____

Policy holder ID: _____Group ID:_____

Policyholder's Name: _____ Date of Birth_____ Sex: ☐ Male ☐Female

Policyholder's SS#:: _____ Relationship to patient: _____

Patient Consent

Request for Care and Consent for Treatment

The undersigned consents to the medical care and treatment, as may be deemed necessary or advisable in the judgment of my physician or other provider, which may include but are not limited to laboratory procedures, X-ray examination, medical or surgical treatment or procedures or other services rendered to the patient under the general and special instructions of the patient's physician. Gastro Florida has the right to refuse to treat you if you refuse to sign this consent or if, at any time, you choose to revoke this consent.

Assignment of Insurance Benefits

I authorize payment directly to Gastro Florida of any insurance benefits otherwise payable to me for services, at a rate not to exceed Gastro Florida regular charges for such services**.**

Authorization to Release Information

I authorize the release of medical records and related information from Gastro Florida to authorized representatives of my third party payor or physician related to my care. I authorize review of records for any necessary agency audit and the release of the physician plan of care and discharge summary from my medical record upon my transfer to or from another health care facility.

Permission for Treatment

Permission is hereby granted for physicians and employees or agents of the Practice to render the patient named below such medical and surgical treatment as is deemed necessary.

The undersigned certifies that he/she has read the forgoing, received a copy therof and is the patient or is duly authorized by the patient as patient's general agent to execute the above and accepts its terms.

_____ _____

Patient/ Guardian Signature Date

_____

Printed Name of Person Signing Consent Form

If other than the patient (Patient Name)_____ is signing, are you the legal guardian, custodian or have Power of Attorney for this patient, for treatment, payment or healthcare operations? ☐ Yes ☐ No

OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to the success of your treatment. Please understand that payment of your bill is considered part of your treatment arrangement. The following is a statement of our Financial Policy, which we require you to read prior to any treatment.

All patients must complete our Registration and History forms before seeing the doctor. You must supply us with both your insurance card and driver's license prior to your visit.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, or VISA/MASTERCARD/DISCOVER.

Statement of Financial Responsibility
I understand that I am responsible for the payment of this account, and hereby assume and guarantee prompt payment of all the expenses incurred.

Notice of "Non-Covered" Services
I am aware that some services performed by the practice may be considered "non-covered" by my insurance carrier or Medicare, therefore I will become fully responsible for payment of these services.

Waiver of "Usual, Customary and Reasonable" Clauses (*For patients with "Out-of-Network" coverage)*
I acknowledge that the fee charged by the Practice for services rendered to me, or to the person for whom I assume financial responsibility, may exceed the fee considered "usual, customary and reasonable", due to specialized services and staff. However, I agree to pay the Practice fees in full, even if the amount is greater than what I am reimbursed from my insurance company.

Bill To/Payment Instructions

_____ Commercial Insurance/Third Party Payor _____ Medicare _____*Medigap
Initial Initial Initial

I hereby authorize the Practice to bill my insurance company and/or Medicare (indicated or initialed above) for services provided to me and request that payment for such services be made to the Practice on my behalf.

***If Medigap** _____ _____ _____
Name of Beneficiary Medigap Policy Number Health Insurance Claim Number

List Names of Those Whom You Want Us to Share Your Financial Responsibility Information:

Name: Relationship:

_____ _____

_____ _____

_____ _____

Financial Agreement
The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the service to be rendered to the patient, he/she obligates himself/herself to pay the account of the Practice in accordance with the regular rates and terms of the Practice. Should the account be referred to an outside agency or an attorney for collections, the undersigned agrees to pay reasonable collection and attorney fees for collection expenses.

Billing Questions
Please address all billing questions to our Central Business Office (727) 347-0005.

Payment Plans
You can call our Central Business Office to determine if you qualify for this arrangement.

Patient Name: _____
(please print)

Patient (or legal guardian's) signature:_____ _____
Date

_____ _____
Witness Date

Gulfcoast Gastroenterology Consultants

Diplomates American Board of Gastroenterology and Internal Medicine

Please Print

HEALTH QUESTIONNAIRE

NAME _____ DATE _____

ADDRESS _____

Personal Physician _____ Address _____

Referring Physician _____ Address _____

PLEASE LIST YOUR CURRENT SYMPTOMS AND MEDICAL PROBLEMS:

1. _____ **Please Circle One:** Hispanic / Non-Hispanic
2. _____ **Please Circle One:** Everyday Smoker Some-day Smoker
3. _____ Former Smoker Never Smoker

HAVE YOU EVER HAD:

REG. MEASLES	NO	YES	GER. MEASLES	NO	YES	MUMPS	NO	YES
WHOOPING COUGH	NO	YES	DIPHTHERIA	NO	YES	CHICKEN POX	NO	YES
SMALL POX	NO	YES	SYPHILLIS	NO	YES	GONORRHEA	NO	YES
TYPHOID FEVER	NO	YES	INFLUENZA	NO	YES	PNEUMONIA	NO	YES
TUBERCULOSIS	NO	YES	SCARLET FEVER	NO	YES	RHEUMATIC FEVER	NO	YES
STREP THROAT	NO	YES	POLIO	NO	YES	MENINGITIS	NO	YES

PLEASE LIST ALL OF YOUR HOSPITALIZATIONS IN CHRONOLOGICAL ORDER:

	DATE	HOSPITAL	PROBLEM
1.			
2.			
3.			
4.			
5.			
6.			

PLEASE LIST ANY OTHER SERIOUS MEDICAL CONDITIONS OR ILLNESSES:

1. _____
2. _____
3. _____
4. _____

ANY INJURIES:

1. _____
2. _____
3. _____
4. _____

MEDICATIONS: LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

ALLERGIES:

PENICILLIN	NO	YES	LATEX	NO	YES	_____
SULFA DRUGS	NO	YES	IV DYE	NO	YES	_____
BARBITURATES	NO	YES	SHELL FISH	NO	YES	_____
EGGS	NO	YES	_____			

PERSONAL HISTORY:

PLACE OF BIRTH _____

STATES IN WHICH YOU HAVE LIVED _____ ALCOHOL CONSUMPTION _____

COUNTRIES WHERE YOU LIVED OR VISITED _____ TYPE _____ QUANT. PER WEEK _____

CURRENT OCCUPATION _____ COFFEE, CUPS PER DAY _____ TEA, CUPS PER DAY _____

PREVIOUS OCCUPATION _____ REGULAR EXERCISE : YES : NO TYPE _____

NAME _____ DATE _____

FAMILY HISTORY		AGE	IF LIVING, HEALTH	AGE AT DEATH	IF DECEASED, CAUSE	RECORD THE APPROXIMATE DATE YOU LAST HAD ANY OF THE FOLLOWING:	DATE HAD
FATHER						COMPLETE MEDICAL EXAM	
MOTHER						WOMEN – PAP SMEAR	
☐ BROTHER ☐ SISTER	1.					CHEST X-RAY	
☐ BROTHER ☐ SISTER	2.					TEST STOOL FOR BLOOD	
☐ BROTHER ☐ SISTER	3.					PROCTO	
☐ BROTHER ☐ SISTER	4.					EKG	
☐ BROTHER ☐ SISTER	5.						
HUSBAND OR WIFE							
☐ SON ☐ DAUGHTER	1.						
☐ SON ☐ DAUGHTER	2.						
☐ SON ☐ DAUGHTER	3.						
☐ SON ☐ DAUGHTER	4.						

SYSTEMS REVIEW: Have you had any of the following problems within the past 3 months?

H.	FREQUENT HEADACHES	NO	YES
	MIGRAINE HEADACHES	NO	YES
E.	DOUBLE VISION	NO	YES
	BLURRED VISION	NO	YES
	SPOTS BEFORE EYES	NO	YES
	BLINDNESS	NO	YES
	EYE PAIN	NO	YES
	GLAUCOMA	NO	YES
	NEED FOR GLASSES	NO	YES
E.	EAR INFECTION	NO	YES
	RINGING IN EARS	NO	YES
N.	NOSE BLEEDS	NO	YES
	DISCHARGE	NO	YES
	LOSS OF SMELL	NO	YES
	FREQUENT COLDS	NO	YES
	POST NASAL DRIP	NO	YES
T.	FREQUENT SORE THROAT	NO	YES
	CHRONIC HOARSENESS	NO	YES
	STREP THROAT	NO	YES
PULM.	CHRONIC COUGH	NO	YES
	COUGHING BLOOD	NO	YES
	SPUTUM PRODUCTION	NO	YES
	SHORTNESS OF BREATH	NO	YES
	ASTHMA	NO	YES
CV.	CHEST PAIN	NO	YES
	HEART ATTACK	NO	YES
	PALPITATIONS	NO	YES
	CALF PAIN	NO	YES
	HEART MURMUR	NO	YES
	HIGH BLOOD PRESSURE	NO	YES
	LOW BLOOD PRESSURE	NO	YES
	FAINTING SPELLS	NO	YES
GI.	PEPTIC ULCER DISEASE	NO	YES
	RECUR. ABDOMINAL PAIN	NO	YES
	BLACK OR BLOODY STOOLS	NO	YES
	VOMITING BLOOD	NO	YES
	VOMITING	NO	YES
	CHANGE IN BOWEL HABITS	NO	YES
	CHANGE IN STOOL APPEAR	NO	YES
	CONSTIPATION	NO	YES
	DIARRHEA	NO	YES
	INTEST. PARASITES (worms)	NO	YES
	DIFFICULTY SWALLOWING	NO	YES
	FREQUENT HEART BURN	NO	YES
	HIATUS (HIATAL) HERNIA	NO	YES
	GALLSTONES	NO	YES
	HEPATITIS	NO	YES
	JAUNDICE (Yel. Jaundice)	NO	YES
	CIRRHOSIS OF LIVER	NO	YES
G.U.	KIDNEY/BLADDER INFEC.	NO	YES
	PAIN OR BURN. URINATION	NO	YES
	PUS IN URINE	NO	YES
	BLOOD IN URINE	NO	YES
	URINARY FREQUENCY	NO	YES
	URINARY URGENCY	NO	YES
	URINATING AFTER BEDTIME	NO	YES
	URINARY DRIBBILING	NO	YES
	KIDNEY/BLADDER STONES	NO	YES
ENDO.	RECENT WT. GAIN	NO	YES
	EXCESSIVE SWEATING	NO	YES
	DIABETES (sugar in urine)	NO	YES
	HIGH CHOLESTEROL	NO	YES
N.P.	STROKE	NO	YES
	PARALYSIS OR WEAKNESS	NO	YES
	LOSS OF SENSATION	NO	YES
	SPEECH ABNORMALITY	NO	YES
	CONVULSION	NO	YES
	LOSS OF BALANCE	NO	YES
	DEPRESSION	NO	YES
	CONFUSION	NO	YES
	CRYING SPELLS	NO	YES
	NERVOUS BREAKDOWN	NO	YES
MS	JOINT PAINS	NO	YES
	TENDER, SWOLLEN, RED OR HOT JOINTS	NO	YES
	BACK PAIN	NO	YES
	FREQUENT LEG CRAMPS	NO	YES
HEM	ANEMIA	NO	YES
	TREATMENT ..... DATE		
	BLOOD TRANSFUSION	NO	YES
	WHEN ..... WHY ..... # UNITS		
	EXCESSIVE BLEEDING	NO	YES
	RECURRENT NOSE BLEEDS	NO	YES
	EASY BRUISABILITY	NO	YES
ONC.	LOSS OF APPETITE	NO	YES
	UNEXPLAINED WT. LOSS	NO	YES
	ANY LUMP OR MASS	NO	YES
	REMOVED ..... WHEN		
	UNUSUAL MOLE OR WART	NO	YES
	ENLARGED LYMPH NODES	NO	YES
	MALE ONLY		
	PROSTATE TROUBLE	NO	YES
	DIF. INITIATING STREAM	NO	YES
	INTERRUPTED STREAM	NO	YES
	IMPOTENCE	NO	YES
	FEMALE ONLY		
	DATE OF LAST PERIOD		
	DURATION OF PERIOD ..... DAYS		
	LENGTH OF CYCLE ..... DAYS		
	NO. OF PREGNANCIES		
	EX. FLOW DURING PERIODS	NO	YES
	BLEED. BETWEEN PERIODS	NO	YES

SIGNATURE _____

REORDER # 07-05785-30