Patient Information

Name_____

Last First Middle

Address_____

Address City State Zip

Phone_____

Home Number Cell Number Work Number

Email Address_____

Pharmacy_____

Name Address Number

SS# _____Date of Birth_____

Sex M___F___ Marital Status Married___Divorced___Widow___Single___

Employer_____

Name Address Number

What Is The Primary Language You Speak? _____

What is Your Ethnicity? ____Hispanic or Latino ___Not Hispanic or Latino

What Is Your Race? ___African American ___Asian ___Caucasian ___Other

Emergency Contact

Name_____

Last First Middle

Phone_____

Home Number Cell Number Work Number

Family Doctor Name And Phone Number

_____

Insurance Information

Primary Insurance Name_____

Policy Holders Name_____

Policy Number_____Group_____

Secondary Insurance Name_____

Policy Holders Name_____

Policy Number_____Group_____

Benefit Assignment/Release of Information

I, assign all medical and/or surgical benefits from Medicare, Private Insurance Carrier(s), and any other health plan coverage to which I am entitled to Chris Demetriou MD P.C., to receive payment for their services. A photo copy or facsimile of this assignment is to be considered as valid as the original. I, authorize Chris Demetriou MD P.C. to release all information necessary, including Medical Records, to secure such payment. I certify that the information given by me in applying for payment is correct. I understand that I am financially responsible for any balance not covered by my insurance.

_____ _____

Patient Signature Date

PATIENT HIPAA CONSENT FORM

Our Notice of Privacy practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under the law. You have the right to review our notice before signing this consent. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.

I understand that at times I may be notified of test results by phone (Check all that apply).

_____I allow my doctor's office to leave messages on my home phone and cell phone

_____I allow my doctor's office to leave a message with the specified family members

_____

_____ _____

Patient Signature Date

GI DOCTORS P.C.

DR. DEMETRIOU & DR. SAHA

Name_____

Date_____

REASON YOU ARE SEEING THE DOCTOR

_____

_____

WHO REFERED YOU

_____

HAVE YOU EXPERIENCES ANY OF THE BELOW CONDITIONS (CIRCLE ALL THAT APPLY)

Seizure	Lupus	Excessive Belching
Stroke	Diabetes	Getting full when you eat
Thyroid Disease	Diabetes	Getting full when you eat
Asthma	Trouble Swallowing	Blood in stool
Emphysema	Barrett's Esophagus	Colon Cancer
Pneumonia	Bloating	Colon Polyps
Sleep Apnea	Pass a lot of gas	Hemorrhoids
Shortness of Breath	Nausea or Vomiting	Anemia
High Blood Pressure	Loss of Appetite	Pancreatitis
Chest Pain	Unwanted weight loss	Gallstones
Heart Disease	Ulcer	Hepatitis A, B, C
Heart Attack	Gastritis	Fatty Liver
Irregular Heart Beat	H/ Pylori	Crohn's Disease
Heart Murmur	Abdominal Pain	Ulcerative Colitis
High Cholesterol	Irritable Bowel Syndrome	Diverticulosis or Diverticulitis
Congestive Heart Failure	Constipation	Kidney not working well
Anxiety or Depression	Diarrhea	Kidney Stone
Cancer	Other	Gout

EVER HAD A COLONOSCOPY OR ENDOSCOPY, SPECIFY DATE

_____

_____

LIST THE SURGERIES YOU HAVE HAD

_____

_____

LIST YOUR CURRENT MEDICATION AND DOSAGE, INCLUDING OVER THE COUNTER MEDS

_____

_____

_____

_____

LIST ANY DRUG ALLERGIES (INCLUDING EGGS, SULFUR, RADIOLOGIC CONTRAST)

_____

_____

LIST THE AGES OF YOUR PARENTS, BROTHERS, AND SISTERS AND RECORS ANY MEDICAL PROBLEMS THEY MAY HAVE, INCLUDING COLON POLYPS, BARRETT'S, OR CIRRHOSIS

_____

_____

_____

LIST THE RELATIVES (PARENTS, SIBLINGS, GRANDPARENTS, UNCLE/AUNTS, COUSINS) WITH CANCER OF THE COLON, ESOPHAGUS, STOMACH, PANCREAS, GALLBLADDER, BREAST, OVARIAN, ENDOMETRIUM, UTERUS

_____

_____

_____

_____

WOULD YOU LIKE ASSISTANCE WITH WEIGHT LOSS AND HEALTHIER EATING HABBITS

YES NO