Patient Interview Form

First Name:	**Middle Initial:**		**Last Name:**	
Address:	**City:**	**State:**	**Zip Code:**	
Social Security #:	**Date of Birth:**	**Sex: (Please circle)** Male Female Other	**Marital Status: (Please circle)** Single Married Separated Divorced Widowed	
Home Phone or Mobile Phone (Best):	**Work Phone:**		**Personal email:**	
Contact Preference: No preference Email Letter/phone Text message Other: _____				
Patient Employer:	**Insurance Name:**	**Policy ID #**	**Policy Holder's Name:**	**Policy Holder's D.O.B.**
Spouse's Name:	**Spouse's Date of Birth:**		**Spouse's SSN:**	
Spouse's Employer:	**Spouse's Work #:**		**Spouse's Mobile #:**	
Emergency Contact (other than spouse):	**Relationship:**		**Phone #:**	**Mobile#:**
Person(s), if any, we may discuss your medical/billing information with:	Name: _____ Relationship: _____		Name: _____ Relationship: _____	
Provider you are seeing today:	**Referring Provider:**		**Reason for visit today:**	
Race: (Please circle one) Black/African American White Asian American Indian/Alaska Native Decline to specify	**Ethnicity: (Please circle one)** Hispanic Not Hispanic or Latino Decline to specify		**Preferred Language: (Please circle one)** English Spanish/Castilian Decline to specify	

***Please answer the following questions as accurately as possible. Your past medical history and your family history are used to determine what your insurance will cover for procedures. Inaccurate information can affect how your claim is paid. Please initial in the box after answering the questions.**

Have you ever had a colonoscopy? ❑ Yes ❑ No

If you have had a colonoscopy: When? _____
Where? _____

Have you ever had a Cologuard® test: When? _____

Have *you* ever had colon polyps? ❑ Yes ❑ No

Have *you* ever had colon cancer? ❑ Yes ❑ No

*** All questions in this box have been answered to the best of my knowledge. _____ Initial**

Has anyone in your *immediate family* ever had colon polyps? ❑ Yes ❑ No

If you answered *yes* to the questions above, please circle which family member had *colon polyps*:

Mother Father Sister Brother Daughter Son

Has anyone in your immediate family ever had colon cancer? ❑ Yes ❑ No

If you answered *yes* to the question above, please circle which family member had colon *cancer*?

Mother Father Sister Brother Daughter Son

Gastroenterology Clinic, APMC - Endoscopy Center of Monroe, Inc. - Endoscopy Center of West Monroe
Notice of Privacy Practices Acknowledgment

I, (patient name - print) _____, acknowledge receipt of the Notice of Privacy Practices.

Signature: _____ Date: _____

Signature of Patient or Representative

I, (employee name - print) _____, certify that I have made a good faith effort to obtain written acknowledgment of the patient's receipt of the Notice of Privacy Practices, but the acknowledgment was not obtained because: _____.

By: _____ Date: _____

Signature of Employee

Review of Systems/Current Symptoms: Please check yes or no

Cardio	Y	N	Genitourinary	Y	N	Neurological	Y	N
chest pain			dark urine			frequent headaches		
difficulty breathing with exercise			frequent urination			numbness or tingling		
irregular heart beat			painful urination			tremors		
palpitations			blood in urine			**Psychiatric**		
peripheral edema			urination during the night			anxiety		
Constitutional			hesitancy			depression		
fatigue			**Hematologic/Lymphatic**			difficulty sleeping		
fever			bleeding gums			panic attacks		
loss of appetite			easy bruising			**Respiratory**		
malaise			prolonged bleeding			cough		
sweats			palpable lymph nodes			difficulty breathing		
weight gain			**Integumentary**			wheezing		
weight loss			dryness					
ENMT			itching					
dizziness			jaundice					
nose bleeds			rashes					
sore throat			**Musculoskeletal**					
hearing loss			back pain					
ringing in ears			muscle weakness					
post nasal drip			stiffness					
hoarseness			Raynaud's disease					
halitosis (bad breath)								

Allergies: ☐ **No known allergies** ☐ **No known drug allergies**

☐ **Penicillin** ☐ **Sulfa** ☐ **Codeine** ☐ **Cephalosporins** ☐ **Erythromycin** ☐ **Eggs** ☐ **Peanuts** ☐ **Latex** ☐ **Soy**

Other Allergies: _____

Pharmacy: _____
Address **Phone**

Consent to Import Medication History

Do you consent to having your medications obtained that have been purchased at your pharmacy?

☐ **Yes** ☐ **No**

Current Medications: ☐ **None**

Name	Dose	Frequency

Immunizations: ☐ **None**

☐ **Covid 19 vaccine** **When:**_____ ☐ **Flu vaccine** **When:**_____ ☐ **Hepatitis B** **When:**_____ ☐ **Hepatitis B-adult** **When:**_____ ☐ **Tetanus toxoid** **When:**_____ ☐ **Pneumonia** **When:**_____

Past or Present Medical Conditions

Gastrointestinal (Upper GI)

	Y	N		Y	N		Y	N		Y	N
Acid Reflux			Anemia			Barrett's Esophagus			Celiac disease		
Delayed gastric emptying			Difficulty swallowing			Esophageal varices			Helicobacter Pylori		
Hiatal hernia			Lactose intolerance			Stomach Cancer			Stomach ulcers		
Other:											

Gastrointestinal (Lower GI)

	Y	N		Y	N		Y	N		Y	N
Colon cancer			Colon polyp(s)			Crohn's disease			Irritable Bowel Syndrome(IBS)		
Diverticulosis			Diverticulitis			Ulcerative colitis			Other:		

Gastrointestinal (Biliary)

	Y	N		Y	N		Y	N		Y	N
Abnormal liver tests			Cirrhosis			Fatty Liver			Gallstones		
Hepatitis A			Hepatitis B			Hepatitis C			Pancreatitis		
Primary biliary cirrhosis			Other:								

Cardiovascular

	Y	N		Y	N		Y	N		Y	N
Atrial Fibrillation			Blood clots(leg)			Blood clots(lung)			Carotid artery disease		
Congestive Heart Failure			Coronary artery disease			Dyspnea with exercise			Endocarditis		
Heart Attack			High Blood Pressure			High Cholesterol			Irregular heart beat		
Ischemic heart disease			Mitral Valve Prolapse			Stroke			Transient Ischemic Attack(TIA)		
Other:			Other:								

Pulmonary

	Y	N		Y	N		Y	N		Y	N
Asthma			COPD			Emphysema			Daily Oxygen Use		
Sleep apnea			Other:								

Other

	Y	N		Y	N		Y	N		Y	N
Diabetes Type 1			Arthritis			Dialysis Patient			Dementia		
Diabetes Type 2			Chronic back pain			Renal insufficiency			Intellectual Disability		
Seizures			Neuropathy			Sickle cell trait			Cancer: Type-		
Pt is ADOPTED			Glaucoma			HIV			Other:		

Diagnostic Studies/Tests/GI Endoscopy

	Y	N		Y	N		Y	N		Y	N
Bravo pH study			Capsule endoscopy			Colonoscopy			Double balloon small bowel endoscopy		
EGD			ERCP			Esophageal dilation			Esophageal manometry		
Flexible sigmoidoscopy			Hemorrhoid Banding			PEG (feeding) tube					

Radiology Exams

	Y	N		Y	N		Y	N		Y	N
Abdominal x-ray			CT abd/pelvis			Gastric emptying scan			Hida scan w/CCK		
Liver Biopsy			Mammogram screening			MRI			MRCP		
Small bowel series			Ultrasound			Sitzmarker Colon Transit Study					

Previous Procedures

	Y	N		Y	N		Y	N		Y	N
Appendectomy			Small Bowel Resection			Hysterectomy			Cardiac Bypass(CABG)		
Cholecystectomy(gallbladder)			Reflux Surgery			Tubal Ligation			Cardiac stents-when?		
Gastric Lap Band			Hemorrhoidectomy(surgical)			C-Section			Pacemaker Insertion		
Gastric Sleeve			Whipple Procedure			Bladder Suspension			Defibrillator		
Gastric Bypass, unspecified			Tonsillectomy			Mastectomy			Valve Replacement		
Partial Colectomy			Exploratory laparotomy			Prostate Surgery			Carotid Endarterectomy		
Total Colectomy			Knee Surgery			Total Hip Replacement			Hernia Repair, type:		
Colostomy			Back Surgery			Neck surgery			Other:		

Social History

Occupation: _____ Number of children: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Civil Union ☐ Unknown ☐ Other

Alcohol Use: ☐ None

	Type	Quantity	Frequency
☐	Beer		
☐	Wine		
☐	Liquor		

Tobacco

Smoking Status ☐ Current every day smoker ☐ Current some day smoker ☐ Former smoker ☐ Never smoker
☐ Smoker, current Status unknown ☐ Light tobacco smoker ☐ Heavy Smoker ☐ Unknown if ever smoked

	Type	Started	Quit	Quantity	Frequency
☐	Cigarettes				
☐	Smokeless				
☐	Vape				
☐	Other				

Drug Use ☐ None

	Type	Quantity	Frequency
☐	Currently uses illicit drugs		
☐	Used illicit drugs in the past		
☐	Currently uses recreational drug(s)		
☐	Legal/prescription marijuana use		

Family Medical History (This section pertains to your family, *not* your personal medical history)

	Y	N	If yes, who in your family?	Age of diagnosis
Celiac sprue				
Colon cancer				*(required)-*
Colon polyps				
Crohn's Disease				
Liver disease				
Ulcerative Colitis				

Consent to Share Data

I consent to having my medical and demographic information shared with other health care entities. ☐ Yes ☐ No

Reminder Preference

I would like to receive preventive care and follow up care reminders. ☐ Yes ☐ No

Patient Signature _____ **Date** _____

Reviewed with: ☐ **Patient** ☐ **Parent** ☐ **Guardian** ☐ **Not Present**

Staff Signature _____

AUTHORIZATION TO PAY BENEFITS

I (patient name - print) _____ hereby authorize payment of surgical and/or medical benefits directly to Gastroenterology Clinic, APMC (herein after GCM) and Endoscopy Center of Monroe, Inc. (herein after ECM) and further convey transfer and assign all of my rights in my insurance coverage to GC and ECM for services rendered. I also hereby assign and transfer any and all rights, title, and interest to any claim for penalties and/or attorney fees arising under any state or federal law or regulation related to the payment of any claim for benefits to GC and ECM. Regardless of the extent of the insurance coverage, I agree to be responsible for the entire balance. I also authorize release of information pertaining to my claim to my insurance company and/or companies or my attorney. Once the provider has obtained the patient's one-time authorization, the provider may submit any later claim on either an assigned or unassigned basis without obtaining any additional signature from the patient. In submitting claims, the provider should indicate "Patient request for payment on file." I hereby authorize GC and ECM to furnish information to any requesting physician.

_____

Patient Signature Date

MEDICARE AUTHORIZATION

I (patient name - print) _____ certify that the information given by me in applying for a payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary of carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf once the provider has obtained the patient's one time authorization. The provider may submit any later Medicare claim on either an assigned or unassigned basis without obtaining any additional signature from the patient. In submitting claims, the provider should indicate "Patient request for payment on file." I hereby authorize Gastroenterology Clinic, APMC and Endoscopy Center of Monroe, Inc. to furnish information to any requesting physician.

_____

Patient Signature Date