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SPECIALIST INFORMATION

Please list your primary care physician as well as any specialist information below in the subsequent sections such as cardiologist (heart doctor), rheumatologist (arthritis doctor), endocrinologist (diabetes doctor), neurologist (stroke or MS doctor), etc. This way we can keep all of your physicians informed about your health. This form will be updated EVERY year & we will as for your signature verifying our records are correct. Thank you, in advance, for your anticipated cooperation.

Patient Name: _____ DOB: _____ Date: _____

Primary Care Physician: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____

Specialist #1: _____ Specialty: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____

Specialist #2: _____ Specialty: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____

Specialist #3: _____ Specialty: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____

Patient Signature: _____ Date: _____

Patient's Initials: _____ Date: _____ Patient's Initials: _____ Date: _____
Patient's Initials: _____ Date: _____ Patient's Initials: _____ Date: _____

Specialist #4: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____

Specialist #5: _____ Specialty: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____

Specialist #6: _____ Specialty: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____

Specialist #7: _____ Specialty: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____

Specialist #8: _____ Specialty: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____

Specialist #9: _____ Specialty: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____

Capital Health Gastroenterology Specialists

New Patient Encounter Form

HISTORY – COMPLETED BY PATIENT, STAFF OR PROVIDER

Please complete this form to the best of your ability.

1. Reason(s) for your visit today: _____

   _____

2. Medical History – Please check all that apply:

☐ Colon Cancer or Polyp	☐ Heart Attack or Angina	☐ Diabetes
☐ Pancreatitis	☐ Pacemaker or Defibrillator	☐ Stroke
☐ Esophageal Cancer	☐ Atrial Fibrillation	☐ Asthma or Lung Disease
☐ Pancreas Cancer	☐ High Blood Pressure	☐ Kidney Disease
☐ Barrett's Esophagus	☐ Elevated Cholesterol	☐ Bleeding Tendency
☐ GERD or Heartburn	☐ Blot Clot in Leg or Lung	

   ☐ Other gastrointestinal diseases, please specify: _____

   _____

   ☐ Other, please list: _____

   _____

3. Please list **ALL** medication(s), supplements you are taking, including dosage & frequency:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. Previous surgeries/dates - Please check all that apply & list date(s) to your best recollection:

☐ Gallbladder _____	☐ Colon _____	☐ Pancreas _____
☐ Esophagus or Stomach _____	☐ Heart Bypass _____	☐ Heart Valve _____
☐ Hysterectomy _____	☐ Other – Please list: _____	

   _____

5. Allergies – Are you allergic to any medication(s)? ☐ No ☐ Yes If yes, please list the medications you are allergic to & your reaction: _____

_____

Do you have any food allergies? ☐ No ☐ Yes If yes, please list: _____

_____

6. Social history?

Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Widow/Widower

With whom do you live? _____

Current occupation/employer: _____

Do you smoke? ☐ Yes ☐ No If yes, how many packs a day? _____ For how many years? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks a day? _____ a week? _____ a month? _____

Are you sexually active? ☐ Yes ☐ No Do you use illicit drugs? ☐ Yes ☐ No If yes, what kind?

_____

7. What is the health status of your family?

Mother: _____ Father: _____

Brothers/Sisters: _____

Family Illnesses:

History of Colon Cancer? ☐ Yes ☐ No

History of Pancreatic Cancer? ☐ Yes ☐ No

Other Cancer? ☐ Yes ☐ No If yes, site _____

8. Review of Systems – Do you have signs or symptoms in any of the following areas? Please check all that apply.

Yes	No		Yes	No	
		Constitutional			**Cardiovascular**
☐	☐	Fever, sweats or chills	☐	☐	Chest pain
☐	☐	Fatigue, anorexia	☐	☐	Palpitations
☐	☐	Weight loss >5lbs	☐	☐	Ankle swelling
		Skin	☐	☐	Difficulty breathing upon lying down
☐	☐	Rashes			**Respiratory**
☐	☐	Jaundice	☐	☐	Shortness of breath
		Eyes	☐	☐	Cough
☐	☐	Dry eyes or eye irritation	☐	☐	Sputum production
☐	☐	Change in vision	☐	☐	Snoring
		Ears, Nose, Mouth & Throat	☐	☐	Dry mouth, mouth ulcers
☐	☐	Nose, sinus problems	☐	☐	Sore throat
☐	☐	Earache			**Psychiatric**
☐	☐	Allergies	☐	☐	History of anxiety or depression
		Gastrointestinal	☐	☐	Sleep disturbances
☐	☐	Heartburn or indigestion			**Neurological**
☐	☐	Difficulty swallowing	☐	☐	Headache
☐	☐	Nausea or vomiting	☐	☐	Focal weakness or numbness
☐	☐	Abdominal pain	☐	☐	Loss of consciousness
☐	☐	Jaundice or hepatitis	☐	☐	Dizziness, fainting
		Genitourinary			**Musculoskeletal**
☐	☐	Frequent, difficult or painful urination	☐	☐	Muscle aches
☐	☐	Nocturia	☐	☐	Arthritis or arthralgia
☐	☐	Irregular menstrual periods or vaginal bleeding			
☐	☐	Urethra or vaginal discharge			

Other symptoms – Please list: _____

_____

Physician comments – Review of Systems: _____

_____

I have personally review the information recorded in the above three pages

Attending Signature _____ Date _____

General & Financial Consent: Capital Health Medical Group

Consent for Treatment:

I consent to be treated by Capital Health Medical Group under the care of my physician and/or psychotherapist, his/her associates, partners, assistants and designees. I consent to the care which encompasses routine laboratory, diagnostic, medical/surgical, and/or psychotherapeutic treatment advisable during treatment. I agree to allow medical, psychology, social work, and nursing trainees, under the supervision and direction of a physician or other licensed provider, to observe my treatment and review my medical record. I understand no guarantees have been made to me about the outcome of this care. I acknowledge Capital Health has the authority to dispose of specimens taken for laboratory and pathology examination.

_____ _____

Signature of Patient or Authorized Person (Address/Relationship) DATE/TIME

Financial Agreement:

I agree whether I sign as a representative of the patient or as the patient, that in consideration of the services to be rendered to me, I obligate myself to pay the account of Capital Health Medical Group in accordance with the regular rates and terms of the group. I intend to be legally bound, assume full responsibility for and agree to pay Capital Health upon presentation of the bill, all expenses and charges for such services and care. Should the account be referred to an attorney for collection, I shall reimburse Capital Health reasonable attorney's fees and collection expense.

Medicare Authorization for Information and Payment Request Release:

I agree the information given to me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about the patient to release to Social Security Administration or its intermediaries or carriers or to the Professional Review Organization any information needed in order to process payment for this visit or a related Medicare claim. I request that payment or authorized benefits be made on my behalf, if I am a member of a Medicare Risk Contracting Health Maintenance Organization.

If I have Medigap coverage, I request that payment of authorized Medigap benefits be made either to me or on my behalf to Capital Health Medical Group for any services furnished to me by that physician or supplier. I authorize any holder of Medicare information about me to release any information needed to determine these benefits payable for related services.

Release of Information:

I assign benefits payable for physicians' services to the physician or provider furnishing services and authorize such physician or provider to submit a claim containing information related to my treatment, to Medicare, Medicaid or other Insurance Carrier for payment. I understand that if under Medicare Program Guidelines, as necessary, Capital Health Medical Group is required by various governmental agencies to review and release patient information. Capital Health Medical Group also cooperates with various agencies by providing statistics and medical information for research purposes. I understand and agree that Capital Health is authorized to review and release such information. I understand that these records will contain information pertaining to psychiatric, alcohol or drug abuse and HIV counseling or testing. Any specimens taken from my body during treatment may be retained, preserved, used for teaching purposes, or disposed of by Capital Health Medical Group.

Consent to Release Medical Records:

I authorize the release of my medical records and information for the purpose of coordinating care and discharge planning and for the purpose of my follow-up are, this includes designated Care Giver, if elected. I understand that the information disclosed may include Specially Protected Health Information such as records of psychiatric treatment, counseling or testing, substance abuse counseling or treatment, and/or HIV/AIDS diagnosis, treatment or testing. I may revoke this authorization as it related to Specially Protected Health Information by providing written notice to Capital Health Medical Group.

Consent for Blood Test:

In the event a physician, employee, worker or student is accidentally stuck with a needle or otherwise directly exposed to my blood or body fluids, I consent to having my blood tested for Human Immunodeficiency Virus (HIV, the virus that causes Acquired Immune Deficiency Syndrome, AIDS). Such testing will allow any necessary treatment of the physician, employee, worker or student to being without delay. I further understand that if such testing is required I will receive appropriate counseling. The results of the test will be released only to those involved with the medical treatment of the exposed physician, hospital employee, worker or student or as required by law or as agreed to by me.

_____ _____

Signature of Patient or Authorized Person (Address/Relationship) DATE/TIME

Acknowledgement of Privacy Notice: I acknowledge receipt of Capital Health Notice of Privacy Policy

_____ _____

Signature of Patient or Authorized Person (Address/Relationship) DATE/TIME

Patient Name: _____ DOB: _____ Date: _____

Living Will:

Do you have a Living Will and Durable Power of Attorney? **YES** **NO**

If **YES**, please furnish us with a copy for your medical chart or allow us to make a copy to attach to your chart. Thank you.

If **NO**, would you like more information regarding this subject? **YES** **NO**

I. When we need to contact you regarding test results, prescription refills, rescheduling appointments, etc., Please indicate where we can leave a message:

CIRCLE YES OR NO

HOME NUMBER ~ YES / NO _____

CELL NUMBER ~ YES / NO _____

II. I AUTHORIZE THE FOLLWING INDIVIDUALS TO RECEIVE INFORMATION PERTAINING TO MY MEDICAL CARE.

NAME	RELATIONSHIP	CONTACT NUMBERS

I agree _____ to the above. Date Signed: _____
(Patient Signature)

Signing this form verifies all information is correct and /or has been updated.

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Medication History & Medication Benefits Consent

I give permission for Capital Health to obtain my current Medications and Medication History from the Surescripts Pharmacy Clearinghouse.

I understand that this information will be stored in my Electronic Health Record and may be used in the normal course of my treatment at Capital Health.

Patient Signature: _____ Date: _____

Missed Appointment Policy

Our goal is to provide quality individualized medical care in a timely manner. "No-shows" and late cancellations inconvenience those individuals who need access to medical care in a timely manner. We would like to remind you of our office policy regarding missed appointments. This policy enables us to better utilize available appointments for our patients in need of medical care.

Cancellation of an Appointment

In order to be respectful of the medical needs of other patients, please be courteous and call our office promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least **24 hours** in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

How to Cancel Your Appointment

To cancel appointments, please call your office. If you do not reach the receptionist you may leave a detailed message on the voice mail. If you would like to reschedule your appointment, please leave your phone number. We will return your call and give you the next available appointment time.

Late Cancellations: A late cancellation is considered when a patient fails to cancel their scheduled appointment with a **24 hour** advance notice.

No Show Policy: A "no-show" is someone who misses an appointment without cancelling it in an adequate manner. A failure to be present at the time of a scheduled appointment will be recorded in your appointment history as a "no-show".

Missed Appointment Fees

- Patients who fail to keep an appointment will be rescheduled once upon request: **No Charge**
- After a second and subsequent missed appointment: **$25 fee billed to your account**
- Third missed appointment: **Possible discharge from our practice**

Patient Name: _____

Patient's Signature: _____ Date: _____