

GENERAL HISTORY-PLEASE FILL IN BOTH SIDES AND BRING TO OFFICE FOR VISIT

Patient Name: _____ DOB _____ Date _____

1. Reason for your consultation/visit today _____

Family Dr.'s office called and made appt. Patient called and made appt. at request of Family Dr. Patient called on own

2. Please indicate if you are having any current problems, signs or symptoms in any of the following areas:

- | | | |
|--|--|---|
| <input type="checkbox"/> General Wellness | <input type="checkbox"/> Lungs / Breathing | <input type="checkbox"/> Reproductive / Urinary |
| <input type="checkbox"/> Eyes | <input type="checkbox"/> Heart / Circulation | <input type="checkbox"/> Thyroid / Endocrine |
| <input type="checkbox"/> Skin | <input type="checkbox"/> Muscles / Joints, Bones | <input type="checkbox"/> Psychiatric |
| <input type="checkbox"/> Ears, Nose, Throat | <input type="checkbox"/> Neurological | <input type="checkbox"/> Blood / Lymph |
| <input type="checkbox"/> Stomach / Digestion | <input type="checkbox"/> Allergies | <input type="checkbox"/> Other _____ |

3. Are you currently taking: Aspirin / Coumadin / Plavix / Lovenox / Pletal / Aggrenox

4. Medication(s) (drugs, pills): _____

5. Past Medical History / Previous Surgeries / Dates: _____

6. Allergies to medications? Yes No If yes, please list allergy and what the reaction is (ex: rash, hives, etc.)

7. General / Social history of patient: Marital Status: Single Married Divorced Widow/Widower

Who lives with you? _____

Do you smoke? _____ How many packs a day? _____ For how many years? _____

Do you drink alcohol? _____ How many drinks per day? _____ Per week? _____ Per month? _____

History of Heart Disease (heart attack, heart failure) Yes No History of strokes? Yes No

Do you have any artificial heart valves, knee or hip joints? - If yes, please list specific area and date of procedure: _____

Do you have an AICD (Automated Internal Cardiac Defibrillator) or a pacemaker? Yes No

Do you have a history of renal or kidney disease? Yes No History of Diabetes? Yes No

History of Cancer? Yes, site _____ No History of High Blood Pressure? Yes No

8. What is the Health Status of your Family?

History of cancer for Mother, site: _____ Father, site: _____ Other, site: _____

9. Have you had any recent blood work, x-rays, sonograms or scans done relating to your visit today? Yes No

If yes, what did you have done, where and when: _____

REVIEW OF SYSTEMS

Patient Name: _____

Date of Birth: _____

CONSTITUTIONAL:

Fever Chills Night Sweats Fatigue Loss of Appetite NONE

EYES:

Blurred vision Double Vision Discharge Itching Pain Redness
 Sensitive to light Yellow eyes NONE

EARS, NOSE, THROAT, MOUTH:

Ears: Pain Bleeding Drainage Ringing Hearing loss NONE

Nose: Bleeding Congestion Discharge NONE

Throat: Pain Swelling Voice Change Hoarseness NONE

Mouth: Bleeding Pain Swelling NONE

RESPIRATORY:

Cough Shortness of Breath Wheeze Cough up Blood Pain w/breathing NONE

CARDIOVASCULAR:

Chest Pain Arm pain Swelling of Legs Heart fluttering Dizzy Spells
 Passing out NONE

GASTROINTESTINAL:

Abdominal pain Nausea Vomiting Diarrhea Black Stools Constipation NONE
 Vomiting of Blood Bright red blood per rectum Trouble Swallowing Heartburn

GENITOURINARY:

Pain w/urine Blood in urine Frequency Incontinence Flank Pain NONE

Male: Discharge Penile Sore Testicle: Pain Swelling NONE

Female: Discharge Abnormal bleeding Pelvic pain Pregnant Pain w/intercourse NONE

NEUROLOGICAL:

Headache Dizziness Seizure Speech problem Problem walking
 Weakness Tremor Fainting Numbness NONE

MUSCULOSKELETAL: Pain or swelling in:

R L Neck Chest wall Rib(s) Back Shoulder Arm Elbow Forearm
 Wrist Hand Pelvis Hip Leg Knee Ankle Foot NONE

SKIN:

Rash Itching Jaundice Wounds NONE

HEMATOLOGIC:

Easy Bruising Easy Bleeding Swollen Glands NONE

ENDOCRINE:

Weight: Gain _____ lbs. Loss _____ lbs.
Intolerance to: Cold Heat
Excessive: Thirst Hunger Urination NONE

PSYCHIATRIC:

Depression Anxiety Sleepless Hopeless Suicidal Hallucinations NONE

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND
CONSENT TO USE AND DISCLOSE HEALTH INFORMATION**

This acknowledgement of notice and consent authorizes Bayfront Digestive Disease Associates, P.C. to use and disclose health information about you for treatment, payment and health care operations purposes.

Notice of Privacy Practices. Bayfront Digestive Disease has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgement and consent.

Amendments. We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

How to contact our Privacy Officer

Mail: Bayfront Digestive Disease Associates, P.C.
Attn: Privacy Officer
100 Peach Street, Suite 200
Erie, PA 16507
Telephone: (814) 456-7733
Facsimile: (814) 456-7213

Acknowledgement and Consent

I have received the Notice of Privacy Practices for Bayfront Digestive Disease Associates, P.C. Bayfront Digestive Disease is authorized to use and disclose health information about _____ (patient name) for treatment, payment, and healthcare operations purposes consistent with its Notice of Privacy Practices.

Signature of patient
(or patient's personal representative)

Date

Personal representative information (if applicable): _____
Name of personal representative

_____ (relationship to patient or other authority)

BAYFRONT DIGESTIVE DISEASE FINANCIAL POLICY

We are committed to providing you with the best possible care available at a cost that is both fair and reasonable. The following is a summary of our financial policy. Bayfront Digestive Disease Associates, P.C. is dedicated in helping you receive your maximum benefits available. In order to achieve this goal, we need your assistance and your understanding of our payment policy. We would be happy to provide you further clarification if necessary. We must emphasize that as medical providers our relationship is with you, not your insurance company. We ask that you read and sign the following to acknowledge that you have been advised of your financial responsibility for medical services provided by us.

IT IS YOUR RESPONSIBILITY TO PROVIDE US WITH COMPLETE INSURANCE INFORMATION INCLUDING SUBSCRIBERS NAME, DATE OF BIRTH, ADDRESS, SS# AND EMPLOYER AND TO INFORM US OF ANY CHANGES THROUGHOUT THE YEAR. WE CANNOT FILE CLAIMS WITHOUT THIS INFORMATION.

- We accept cash, checks, money orders, Visa, MasterCard and Discover.
- **Co-payments for office services are required at the time of your visit. If you fail to bring your co-pay, we may have to reschedule your office visit with us.**
- Our office submits insurance forms as a courtesy and service to our patients. We are not obligated to perform this service except for plans which we have a participating agreement.
- All charges are your responsibility from the date services are rendered and are to be paid in full within 90 days.
- Returned checks are subject to a handling fee of \$25.00.
- The cost of medical care is determined by the nature and complexity of the illness. There is no "flat rate" for examinations and treatment.
- Always return your statement stub with your payment and include your account number if you pay by check. If you do not have the stub, be sure the patient's full name and account number are on your check.
- Regardless of the type of insurance coverage you have, you are ultimately responsible for paying your medical bills. The fees charged at Bayfront Digestive Disease compare favorably with other gastroenterologists in this region.
- Unresolved balances may be placed with an outside collection agency. These unresolved balances may also be subject to finance charges, attorney fees and collection agency fees. **Once an account has been placed for collection, future appointments will be at the discretion of the physician and the full collection balance needs to be paid before any further service is provided.**

YOU MUST REALIZE THAT:

1. Your insurance is a contract between you and your employer and/or insurance company. While we may be a provider of services, we are not a party to that contract. We encourage you to contact your insurance carrier personally in order to remain informed of your benefits.

ATTN: WE MAY NOT PARTICIPATE WITH YOUR INSURANCE CARRIER. IT IS YOUR RESPONSIBILITY TO CHECK WITH THEM BEFORE YOUR VISIT.

2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover or which they may consider medically unnecessary, and, in some instances, you will be responsible for these amounts. We will make every effort to ascertain your coverage for our services before treatment and will make you aware of our findings. However, this does not guarantee payment from your insurance carrier.

3. NO SHOW office visit appointments and appointments that are not canceled at least 24 hours in advanced will be charged an office visit fee of \$50.00. NO SHOW procedures and procedures that are not canceled at least 24 hours in advance will be charged a \$150.00 fee. This fee is charged to me and not my insurance. I agree to pay this fee.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise or if you have any questions regarding the above information, we encourage you to contact our Business Manager who will be happy to discuss any financial issues with you.

**OUR PHYSICIANS DO NOT HANDLE ANY FINANCIAL ISSUES.
PLEASE DISCUSS THESE ISSUES WITH OUR BUSINESS MANAGER.**

I understand that I have financial responsibility for payment of medical services provided by Bayfront Digestive Disease Associates, and hereby assume and guarantee payment of all expenses incurred during my office visit and any further treatment. Should legal action be required to secure payment of this account, I agree to pay the legal expenses incurred by this office.

I HAVE READ AND UNDERSTAND THIS FINANCIAL POLICY AND AGREE TO ACCEPT RESPONSIBILITY AS DESCRIBED.

Signature of Patient/Responsible Party

Date

Patient's Name

Patient's Date of Birth

PATIENT INFORMATION SHEET

PLEASE PRINT INFORMATION

Name: _____

Nickname/AKA: _____

SSN#: _____

Next of Kin: _____

Address: _____
(Full Address needed if using a PO Box #)

Telephone: () _____ - _____

Apt #: _____

Relationship to pt: _____

City, St: _____

Emergency Contact: _____

Zip Code: _____

Telephone : () _____ - _____

Phone # () _____ - _____

Relationship to pt: _____

Email: _____

Is there a better day / time of day to call:

Family Doctor: _____

Doctor requesting today's visit with us:

Birthdate: _____ Sex: M F

Marital Status: S M W D Sep

Patient Employer: _____

Address: _____

City, St: _____

Zip Code: _____

Work Phone: () _____ - _____

Today's Date: _____

PATIENT INSURANCE INFORMATION

Primary Subscriber Name: _____

Subscriber Birth Date: _____ M F

Subscriber SSN#: _____

Subscriber Employer: _____

Insurance Co # 1: _____

ID# _____

Group # _____

Insurance Co # 2: _____

Secondary Insured Name: _____

Secondary Insured SSN#: _____

Secondary Date of Birth: _____

List any family members or other people we can discuss your medical care with (example: checking appt. time, test or lab results, meds)

IF YOU CHOOSE NOT TO LIST ANYONE, WE WILL NOT RELEASE ANY INFORMATION ABOUT YOU.

_____/_____
(name of representative) (relationship)

_____/_____
(name of representative) (relationship)

SIGNATURE REQUIRED ON BACK OF FORM