

PATIENT INFORMATION FORM

PI Entry Initials _____

New Insurance Info Y N

Today's Date		Social Security #	
Patient Name			
Address		City, State, Zip Code	
Email Address:			
Date of Birth	Sex : M or F	Marital Status	
Race (Please circle):	White Black/African American American Indian/Alaska Native Other: _____	Ethnicity (Please circle):	Latino or Hispanic Non Hispanic Other: _____
Preferred Language (Please circle):		English Spanish Other: _____	
PCP	Referring Dr.		
Home Phone	Cell Phone	Work Phone	
Can we leave a message with test results on your phone or with a family member?			
Is it best to leave a message at your Home, Work, or Cell phone?			
Emergency Contact		Contact Phone:	

Employer Name	Employer Address
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Primary Insurance Company:	Claims Address:
Policy Holder	Policy Holders SS #
Policy Holder's DOB	Policy # and Group #
Relationship to Holder:	Policy Holders Employer

Secondary Insurance Company:	Claims Address:
Policy Holder	Policy Holders SS#
Policy Holder's DOB	Policy # and Group #
Relationship to Holder:	Policy Holders Employer

ASSIGNMENT OF BENEFITS I authorize payment of medical benefits to myself or Arapahoe Gastroenterology, P.C., for professional services rendered. I authorize payment of medical benefits to myself, Arapahoe Endoscopy Center, or the Endoscopy Center at Porter for facility services rendered.

RELEASE OF INFORMATION I authorize release of any medical information necessary to process all present and future claims and I also authorize release of any medical information to members of the care team.

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY This information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered, including reasonable attorney's fees and cost of collections in the event of a default. I further understand that if payment becomes 90 days past due, Arapahoe Gastroenterology, Arapahoe Endoscopy Center and/or the Endoscopy Center at Porter will begin pursuing collection activity.

NOTICE OF PRIVACY PRACTICES I acknowledge that I have been offered access to Arapahoe Gastroenterology's Notice of Privacy Practices via www.arapahoegi.com, the posted form, and/or a hard copy provided at the reception desk.

NO SHOW / CANCELLATION POLICY I acknowledge that I will be personally billed, (not my insurance) for any no-show or cancellation (less than 48 hours) in the amount of \$25.00 for an office visit and \$50.00 for an endoscopy procedure.

CO-PAY POLICY I acknowledge that I am responsible for paying my co-pay amount to Arapahoe Gastroenterology, Arapahoe Endoscopy Center, or the Endoscopy Center at Porter prior to any appointment. If I fail to comply, I acknowledge that I will be personally billed (not my insurance) a \$15 fee.

ACCESS TO INFORMATION I acknowledge that I have access to a clinical summary at the conclusion of my visit, and unless I specifically request a copy of this document, I will be deemed to have declined said copy. If this clinical summary is provided, I authorize release of this information to myself and members of the care team.

Patient Signature (or parent if minor)

Date

****Please Fill Out Form in Entirety to Ensure Proper Handling of Your Account****



Medical History Form

	Yes	No	If Yes – Please Explain
Are you on any Current Medications? (Please list medication and dose)			
Do you have any Allergies to Medicines?			
Any Previous Abdominal Surgeries?			
Any Other Medical Conditions?			
Have you had a colonoscopy or flex sig?			
Have you had any other GI tests? (ie:Fecal Occult Blood Test, barium enema, etc...)			

Have you ever been diagnosed with:	Yes	No	If Yes - At what age
Colorectal Cancer			
Endometrial or Ovarian Cancer			
Colon Polyps			
• Prior to the age of 40?			
• Multiple polyps removed?			
Celiac Disease			
Hemochromatosis			

Has a Family Member ever been diagnosed with: (including parent, sibling, child, grandparent, aunt, or uncle)	Yes	No	If Yes – Who and at what age
Colorectal Cancer			
Endometrial or Ovarian Cancer			
Colon Polyps			
• Prior to the age of 40?			
• Multiple polyps removed?			
Celiac Disease			
Hemochromatosis			

Have you ever been diagnosed with :	Yes	No
Inflammatory Bowel Disease		
If yes, Is your IBD managed so your quality of life is not affected?		
Crohns		
Ulcerative Colitis		
Would you like to have an Office Appt. to discuss treatment options for these?		

Reason for Today's Visit? _____

Patient Signature

Today's Date

«PNumber»

Today's Date - «ApptDate»

«PName» understands that he/she is being seen here today for a

(Please check one)

- Consultation for Colorectal Evaluation
- Consultation for Other Medical Condition _____
- Follow Up Visit (Established Patient Visit)
- New Patient Visit (Not referred, or no visit in the past 36 months)
- Other _____

with «ApptResDesc»

He/She understands that any information from today's visit will be communicated

with «RFName» his/her Primary Care Provider.

