

PATIENT INFORMATION FORM

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
PCP			
Home Phone		Work Phone	Cell Phone
Can we leave a message with test results on your phone or with a family member? Y / N			
Is it best to leave a message at your Home, Work, or Cell phone?			

Name of Spouse	Spouse's Phone:
Name of Contact (Not at same address)	Contact's Phone:

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.

Copay Policy

I acknowledge that I am responsible for paying my copay 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 \$15.00 fee.

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

Today's Date - _____

_____, 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 Dr _____

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

With Dr _____, his/her Primary Care Provider.

INTAKE AND AUTHORIZATION FORM

Today's Date		Chart #	
Patient Name			
Date of Birth		Sex :	
		SS#	
Home Phone		Work Phone	
		Cell Phone	
Primary Insurance			Secondary Insurance
If HMO – Do you have a referral?		Did you sign an Insurance Waiver?	
Ins Policy Holder			PCP
Patient Weight			

Please Answer	Y	N	Please Answer	Y	N
Latex Allergy			Claustrophobic		
Shellfish / Iodine / Contrast Allergy			Hearing Aide		
Other allergies – please list			Metal Implants or Braces		
Asthma			Body Piercing		
Pacemaker - PROVIDE ID CARD			Tattooed Eyeliner		
Defibrillator - PROVIDE ID CARD			History of Metal Removed from Eyes		
Artificial Heart Valves					
Taking Coumadin, Plavix, Warfarin, or Lovenox					
Oxygen			Mental status of patient intact		
Renal/Kidney Problems			Language Barrier		
Diabetic			Nursing Home Patient		
If diabetic, are you taking <u>Glucophage</u> ?			Wheelchair bound		
Constipation / IBS			Do you understand why you are having this Procedure?		

******For Office Use Only******

Location: AEC PEC Radiology Location _____ Hospital Only _____ Mac _____ General _____

Procedure _____ CPT Code _____

Diagnosis _____ ICD-9 Code _____

CT: Abdn Pelvis IV/Oral w/o contrast contrast If patient is over 60 years old needs: BUN-CREATINE
Ordered? Y N

Labs Ordered or Complete EUS: Radial or Linear Fine Needle Aspiration? Y N Upper Lower

R/O _____ Scheduler _____

Scheduled Date _____ Time _____ Spoke With _____

Scheduled Date _____ Time _____ Spoke With _____

PCP _____ Special Instructions _____

Authorization # _____ Spoke With _____

Provider/PA _____
 Electronically Signed

Sign Off Provider 1 2 3 4 5 6 7 8