Suncoast Internal Medicine Consultants
Patient Registration

Name_____

Preferred Name_____

Address_____

City_____State_____ Zip Code_____

Secondary Address_____

Date of Birth_____Last Four of Social Security Number_____

Marital Status: S M D W Sex: M F Ethnicity: Hispanic or Non Hispanic

Race: American Indian Asian Black Caucasian Pacific Islander Other Prefer Not to Answer

Primary Language_____ Email_____@_____

Employer_____Phone_____

Emergency Contact Name_____Relationship_____

Emergency Contact Phone_____

Referring Physician_____

Pharmacy Name_____Phone_____

Address_____

Insurance Name_____Policy Holder Name_____

Account Number_____Group Number_____

Secondary Insurance Name_____Policy Holders Name_____

Account Number_____Group Number_____

Cancellation/No Show Policy

In consideration of other patients and staff, No Shows and Same Day Cancellations are susceptible to a $50 fee. Cancellations are to be made 24 hours prior to scheduled appointment time.

Assignment of Benefits

I request that payments of any and all authorized insurance benefits be made on my behalf to Suncoast Internal Medicine Consultants for any service or equipment provided to me by the organization.

Responsibility

I understand that it is my responsibility to inform this office immediately of any change in my insurance coverage. I am financially responsible for all fees incurred on my behalf for any service furnished. I am responsible for any balance, Co-Payment, and/or deductible not covered by my insurance. I further agree to pay any fees incurred in the collection of any delinquent charges that I am financially responsible for.

Release of Medical Information

I authorize Suncoast Internal Medicine Consultants to release information concerning my medical care to the Health Care Administration and its agents, and any information needed to determine benefits payable for related services.

Residents and Interns

I understand that Suncoast Internal Medicine Consultants is a teaching facility. Residents, interns and fellows may participate, under the supervision of an attending physician, in my care as part of the Suncoast Internal Medicine education program.

Medicare Recipients Only

I certify the information given by me in applying for payments under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made on my behalf of Suncoast Internal Medicine Consultants for any services furnished to me by any physician. I authorize any holder of medical information about me to release to the Centers for Medicare Services and its agents any information needed to determine these benefits or the benefits payable for the related services.

Privacy Practices

I have been made aware of Suncoast Internal Medicine Consultants Notice of Privacy Practice and that I have a right to receive a copy upon request. This notice describes the types of uses and disclosures of my protected health information that might occur during my treatment, to facilitate the payment of my bills or in the performance of Suncoast Internal Medicine Consultants health care operations. I understand that copies of the Notice of Privacy Practices are available in the lobby of the clinic and on the web site SUNCOASTINTERNALMEDICINE.com.

X_____

Signature of Patient or Personal Representative

DATE_____

_____

Description of Personal Representative's Authority

SUNCOAST
INTERNAL MEDICINE CONSULTANTS
A MULTI-SPECIALTY CLINIC

New GI Patient History

Name_____ Date_____

Reason for Today's Visit_____

Current Other Physicians_____

_____

Drug Allergies:_____

_____

Current Medications: Name Dosage How Often Taken?

_____

_____

_____

_____

_____

Pharmacy Name, Address and Phone Number:

_____

_____

Immunizations: Circle and Date Received:

Hepatitis A_____ Hepatitis B_____ Influenza_____ Varicella/VZN:_____

Past Medical History: ◯ None

Cancers: ◯ Colon ◯ Esophageal ◯ Liver ◯ Small Intestine ◯ Stomach
◯ Kidney ◯ Pancreas ◯ Bladder ◯ Lymphoma ◯ Lung
◯ Skin ◯ Prostate ◯ Breast ◯ Cervical ◯ Ovarian
◯ Uterine ◯ Other: _____

Liver: ◯ Fatty liver ◯ Hepatitis A, Active ◯ Hepatitis B, Active ◯ Hepatitis C, Active
◯ Hepatitis, Autoimmune ◯ Other: _____

Digestive: ◯ Acid Reflux ◯ Barrett 's Esophagus ◯ Celiac Sprue
◯ Cirrhosis of Liver ◯ Colon Polyps ◯ Crohn 's Disease
◯ Diverticulitis (Infected) ◯ Diverticulosis ◯ H. Pylori
◯ Irritable Bowel Syndrome ◯ Pancreatitis ◯ Ulcer
◯ Ulcerative Colitis ◯ Other: _____

Miscellaneous: ◯ Anxiety/Panic Attacks ◯ Arthritis ◯ Asthma ◯ Atrial Fibrillation
◯ Congestive Heart Failure ◯ Coronary Artery Disease ◯ Depression ◯ Diabetes
◯ Emphysema ◯ Endometriosis ◯ Fibromyalgia ◯ Glaucoma
◯ Heart Attack ◯ High Blood Pressure ◯ High Cholesterol ◯ HIV
◯ Kidney Disease ◯ Lupus ◯ Osteopenia ◯ Osteoporosis
◯ Seizure Disorder ◯ Sleep Apnea ◯ Stroke/TIA ◯ Thyroid, Overactive
◯ Thyroid, Underactive ◯ Other: _____

Previous Gastroenterology Procedures: ◯ None
◯ Colonoscopy ◯ EGD/Upper Endoscopy ◯ ERCP ◯ Endoscopic Ultrasound/EUS
◯ Small Bowel Capsule ◯ Other: _____

Surgical Procedures: ◯ None
◯ Appendectomy ◯ C-Section ◯ Cataract Surgery ◯ Colon Resection ◯ Coronary Artery Bypass
◯ Coronary/Stent ◯ Defibrillator ◯ Gallbladder Removed ◯ Gastric Bypass ◯ Heart Valve Replacement/Repair
◯ Hemorrhoidectomy ◯ Hiatal Hernia Surgery (for Reflux) ◯ Hysterectomy, Partial (Ovaries Intact)
◯ Hysterectomy, Total (Ovaries Removed) ◯ Inguinal Hernia Surgery (Groin)
◯ Joint Surgery/Replacement ◯ Lap Band ◯ Liver Transplant ◯ Mastectomy
◯ Pacemaker ◯ Prostatectomy ◯ Tonsillectomy ◯ Tubal Ligation
◯ Ulcer Surgery ◯ Umbilical Hernia Surgery (Belly-Button)
◯ Other: _____ ◯ Other: _____

Social History: **Occupation:** _____

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Separated ◯ Widowed ◯ Other

Alcohol: ◯ None ◯ Less than 7drinks per week ◯ More than 7 drinks per week ◯ I quit using alcohol

Tobacco/Smoking Status: ◯ Current, every day smoker ◯ Current, some day smoker ◯ Former smoker ◯ Never smoked
◯ Smoker, current status unknown ◯ Unknown if ever smoked ◯ Chewing Tobacco/Snuff ◯ Cigar/Pipe Smoker

Drug Use: ◯ None
◯ I have used recreational drugs in the past ◯ I am currently using recreational drugs ◯ I have been treated for substance abuse

Family Medical History: ◯ Unknown/Adopted ◯ No family history of colon cancer ◯ No family history of colon polyps

Diagnosis	Mother	Father	Sister	Brother	Daughter	Son	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Maternal Aunt	Maternal Uncle	Paternal Aunt	Paternal Uncle	Other	Age at Diagnosis
Colon Cancer	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	_____
Colon Polyps	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	_____
Crohn 's/Colitis	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	_____
Liver Disease	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	_____
Uterine Cancer	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	_____
Kidney Cancer	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	_____
Stomach Cancer	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	_____
Bladder Cancer	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	_____
Pancreatic Cancer	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	_____
Ovarian Cancer	◯		◯		◯		◯		◯		◯		◯		◯	_____

Review of Systems:

Please indicate items you are CURRENTLY experiencing or "None " if no symptoms exist:

Gastrointestinal ◯ **None**
- ◯ Abdominal pain
- ◯ Anorectal pain/itching
- ◯ Black, tarry stools
- ◯ Bloating/gas
- ◯ Blood in stool
- ◯ Change in bowel habits
- ◯ Constipation
- ◯ Diarrhea
- ◯ Incontinence of stool
- ◯ Heartburn/reflux
- ◯ Difficulty swallowing
- ◯ Nausea
- ◯ Vomiting

Genitourinary ◯ **None**
- ◯ Blood in urine
- ◯ Dark urine
- ◯ Enlarged prostate
- ◯ Frequent urinary infections
- ◯ Heavy menstruation
- ◯ Pain/burning with urination
- ◯ Pregnancy
- ◯ Sexually transmitted disease
- ◯ Urinary incontinence
- ◯ Frequent urination

Integumentary/Skin ◯ **None**
- ◯ Itching
- ◯ Jaundice
- ◯ Rashes
- ◯ Suspicious lesions

Cardiovascular ◯ **None**
- ◯ Heart murmur
- ◯ Irregular heart beat
- ◯ Hand/ankle swelling
- ◯ Rapid heart rate/palpitations
- ◯ Chest pain

Neurological ◯ **None**
- ◯ Frequent headaches
- ◯ Memory loss/confusion
- ◯ Numbness or tingling

Endocrine ◯ **None**
- ◯ Cold intolerance
- ◯ Excessive thirst
- ◯ Heat intolerance

Constitutional ◯ **None**
- ◯ Chills
- ◯ Fatigue
- ◯ Fever
- ◯ Loss of appetite
- ◯ Night sweats
- ◯ Weight gain
- ◯ Weight loss

Psychiatric ◯ **None**
- ◯ Anxiety
- ◯ Bipolar disorder
- ◯ Depression

Ear/Nose/Mouth/Throat ◯ **None**
- ◯ Double vision
- ◯ Eye irritation
- ◯ Eye pain
- ◯ Eye redness
- ◯ Sore throat
- ◯ Hoarseness
- ◯ Mouth sores
- ◯ Nose bleeds
- ◯ Post-nasal drip
- ◯ Recurrent sinus infections

Hematologic/Lymphatic ◯ **None**
- ◯ Anemia
- ◯ Blood transfusions
- ◯ Easy bruising
- ◯ Prolonged bleeding

Musculoskeletal ◯ **None**
- ◯ Back pain
- ◯ Joint pain

Respiratory ◯ **None**
- ◯ Frequent cough
- ◯ Shortness of breath
- ◯ Snoring
- ◯ Sleep apnea
- ◯ Wheezing

Allergic/Immunologic ◯ **None**
- ◯ Allergies
- ◯ HIV exposure
- ◯ Immune deficiency

Reviewed with: ◯ Patient ◯ Parent ◯ Guardian ◯ Not present/telephone

Signature: _____ **Date:** _____