Advanced Gastroenterology, PLLC / Advanced Endoscopy Center, PLLC

PATIENT REGISTRATION FORM

<table>
<tr><td colspan="2">Date:</td><td colspan="3">Primary Care Physician:</td></tr>
<tr><td colspan="5">PATIENT INFORMATION</td></tr>
<tr><td colspan="2">Salutation:
Name:</td><td colspan="3">Marital Status:
☐ Married ☐ Divorced ☐ Single ☐ Widowed</td></tr>
<tr><td colspan="2">Address:
City, State, Zip:</td><td colspan="2">Date of Birth:</td><td>Sex:
☐ M ☐ F</td></tr>
<tr><td colspan="2">Social Security Number:

Email:</td><td colspan="3">Phone:
☐ Cell ☐ Home ☐ Other:___________

Okay to leave detailed message on voicemail:
☐ Yes ☐ No</td></tr>
<tr><td colspan="2">Employer:</td><td colspan="2">Occupation:</td><td>Employer Phone:</td></tr>
<tr><td colspan="5">Referred by:</td></tr>
<tr><td colspan="5">INSURANCE INFORMATION – (PLEASE SHOW INSURANCE CARD AT CHECK IN)</td></tr>
<tr><td colspan="5">Primary Insurance:</td></tr>
<tr><td>Subscriber's name:</td><td>Birth date:</td><td colspan="2">Group #:</td><td>ID #:</td></tr>
<tr><td colspan="5">Patient relationship with subscriber:</td></tr>
<tr><td>Secondary Insurance:</td><td>Subscriber's name:

Date of birth:</td><td colspan="2">Group #:</td><td>ID #:</td></tr>
<tr><td colspan="5">Patient relationship to subscriber:</td></tr>
<tr><td colspan="5">IN CASE OF EMERGENCY</td></tr>
<tr><td>Name of person to contact:</td><td>Relationship to patient:</td><td colspan="2">Home phone:</td><td>Work phone:</td></tr>
<tr><td colspan="5">The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Advanced Gastroenterology, PLLC/Advanced Endoscopy Center, PLLC or insurance company to release any information required to process my claims.

____________________________________ ______________________
Patient/Guardian Signature Date</td></tr>
</table>

Comments: ____

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Advanced Gastroenterology, PLLC / Advanced Endoscopy Center, PLLC

HEALTH HISTORY – PLEASE PRINT

Name: DOB: Date:

REASON FOR VISIT:____

PRIMARY CARE DOCTOR:____________________________________ ☐ **NO** Primary Care Provider

Medical Problems:

☐ None

☐ Sleep Apnea	☐ Pancreatitis	☐ Crohn's Disease	☐ Kidney Stones
☐ Colon Polyps	☐ Hiatal Hernia	☐ Depression	☐ Osteoporosis
☐ Colon Cancer	☐ Anemia	☐ Diabetes	☐ Parkinson's Disease
☐ Diverticulosis	☐ Anxiety	☐ Fibromyalgia	☐ Rheumatic Fever
☐ Gallstones	☐ Arthritis	☐ Hepatitis, Type____	☐ Seizure Disorder
☐ Heartburn	☐ Asthma	☐ High Blood Pressure	☐ Stroke/paralysis
☐ Irritable Bowel Syndrome	☐ Cataracts	☐ High Cholesterol	☐ Thyroid Problem
☐ Stomach/duodenal Ulcer	☐ Cancer, Type: ________________	☐ Irregular Heartbeat	☐ Other:_____________
☐ Cirrhosis of the Liver	☐ Chronic Lung Disease	☐ Kidney Disease/Failure	

Surgeries/Procedures:

☐ None

☐ Colonoscopy-Date:	☐ Colostomy Bag	☐ Esophageal Manometry/pH Study
Location:_______________	☐ Appendectomy	☐ Hysterectomy
☐ Endoscopy (EGD)-Date: __________	☐ Liver Biopsy	☐ Joint Replacement
☐ Sigmoidoscopy-Date: ____________	☐ Obesity Surgery	☐ Prostate
☐ Gallbladder Surgery	☐ Stomach	☐ Thyroidectomy
☐ Hiatal Hernia Surgery	☐ Breast Surgery-Type:	☐ Tosillectomy
☐ Hemorrhoidectomy	☐ Cardiac Surgery	☐ Tubal Ligation
☐ Colon Resection	☐ C-Section	☐ Other Surgery:

Family History (indicate if maternal or paternal:

History of Heart Disease (heart attack, heart failure)? ☐ Yes ☐ No Who: ________________________

History of Strokes? ☐ Yes ☐ No Who: ________________________

History of High Blood Pressure? ☐ Yes ☐ No Who:_________________

History of Diabetes? ☐ Yes ☐ No Who:__________________________

History of Cancer? Yes No Who: _______________________

History of Crohn's Disease or Ulcerative Colitis (circle one)? ☐ Yes ☐ No Who?__________________

Other: ____

Social History:

Do you currently smoke? ☐ Yes ☐ No How many packs per day? _______________

If you've smoked previously, when did you stop? _____________ How many years did you smoke? _________

Do you drink alcohol? ☐ Yes ☐ No How many? _____________ How often? ☐ Daily ☐ Weekly ☐ Monthly

Do you use recreational drugs (including marijuana)? ☐ Yes ☐ No If yes, what kind? __________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Are you employed? ☐ Yes ☐ No If yes, Occupation:________________________ Employer:_______________

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*PLEASE LIST YOUR PREFERRED **PHARMACY/LOCATION**: ______________________________

*ARE YOU TAKING ANY **ANTICUAGULATION MEDICATIONS**? ☐ Yes ☐ No

Medications – Please list only your *current* medications or provide a list if you have one:

☐ ***Not currently taking any medications***

Name Strength (mg, mcg) Times per day

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

Allergies: Aspirin Morphine Penicillin Sulfa Versed Valium NONE Other:______________________________

Review of Systems - Please indicate if you are ***currently*** experiencing the following:

(If left blank, the assumption is that you are not experiencing any of the below symptoms)

General: ☐appetite change ☐chills ☐diaphoresis (sweats) ☐fatigue ☐fever ☐weight loss ☐NONE

Ears/Nose/Throat: ☐congestion ☐ ear pain ☐hearing loss ☐ nosebleeds ☐sore throat ☐ NONE

Eyes: ☐eye itching ☐ eye pain ☐ eye redness ☐ visual disturbance ☐ NONE

Respiratory: ☐apnea ☐chest tightness ☐ choking ☐ cough ☐ shortness of breath ☐ wheezing ☐ NONE

Cardiovascular: ☐chest pain ☐leg swelling ☐palpitations ☐NONE

Gastrointestinal: ☐abdominal distention ☐abdominal pain ☐ blood in stool ☐ constipation ☐ diarrhea ☐ nausea ☐rectal pain ☐vomiting ☐heartburn ☐acid regurgitation ☐trouble swallowing ☐ NONE

Endocrine: ☐cold intolerance ☐heat intolerance ☐ polydipsia (excessive thirst) ☐ polyphagia (excessive hunger) ☐ polyuria (excessive urination) ☐ NONE

Genitourinary: ☐ difficulty urinating ☐dysuria (painful urination) ☐frequency ☐genital sore ☐hematuria (bloody urination) ☐menstrual problem ☐pelvic pain ☐urgency ☐NONE

Musculoskeletal: ☐arthralgia (joint pain) ☐ back pain ☐joint swelling ☐myalgias (muscle pain) ☐neck pain ☐ neck stiffness ☐ NONE

Skin: ☐color change ☐pallor (paleness) ☐rash ☐wound ☐NONE

Allergic/Immunologic: ☐environmental allergies ☐food allergies ☐immunocompromised ☐NONE

Neurologic: ☐dizziness ☐ headaches ☐ numbness ☐ seizures ☐ syncope (passing out) ☐ tremors ☐ weakness ☐ NONE

Heme/Lymphatic: ☐ adenopathy (enlarged lymph nodes) ☐bruises/bleeds easily ☐NONE

Psychiatric: ☐confusion ☐decreased concentration ☐ dysphoric mood ☐ hallucinations ☐ hyperactive ☐ nervous/anxious ☐sleep disturbance ☐ suicidal ideas ☐NONE

I authorize Advanced Gastroenterology to communicate with and obtain medication history from my pharmacy.

Patient Signature: ______________________________ Date: ______________________________