Center for Digestive Diseases
& Cary Endoscopy Center ™

1120 SE Cary Parkway
Suite 204
Cary, NC 27518
Phone (919) 854-0041
Fax (919) 854-0049
www.centerfordigestivediseases.com

Please take a few minutes to
COMPLETE, SIGN, AND RETURN
All of the **required forms** in this packet
to our RECEPTIONIST on the
DAY OF YOUR PROCEDURE or
the DAY OF YOUR OFFICE VISIT

An Endoscopy nurse will be contacting you
by telephone prior to your procedure
TO REVIEW your
Medical history
and Medication forms.

Thank you.

Center Digestive Diseases and Cary Endoscopy Center, P.C.
Patient Information

Thank you for choosing our office! In order to serve you well, we need the following information. Please print. All your medical information will be kept confidential.

Patient Information:

Name: _____ Birthdate: _____ SS#: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work: Phone: _____ Cell: Phone: _____

Email Address: _____

Marital Status: _____ Spouse's: Name: _____

Employer: _____

Person to contact in an emergency: _____ Phone: _____

Primary Care Doctor: _____ Referring Doctor: _____

Insurance Information:

Primary Insurance:

Insurance Company: _____

ID#: _____ Group #: _____

Policy Holder (if other than patient): _____ Birthdate: _____

Relationship to patient: _____ Employer of Policy Holder: _____

Due to State of North Carolina and Medicare Certification Guidelines, we are **REQUIRED** to report for all patients:
Ethnic Origin, Race, and Primary Language

Please check the appropriate category for each:

Race:

____ American Indian/ Alaska Native
____ Asian
____ Black/ African American
____ Hispanic/ Latino
____ Multiple Race/ Other
____ Native American
____ White
____ Declined / Unavailable

Ethnic Origin:

____ Hispanic/ Latino
____ Non-Hispanic/ Non-Latino
____ Unavailable

Primary Language Spoken: _____ DATE_____

Authorization for Release of Information
To Family and/or Friends

Name of Patient: _____ Date of Birth: _____

Center for Digestive Diseases and Cary Endoscopy Center, PC, is authorized to release protected health information about the above named patient to the entities named below.

Entity to Receive Information. Initial each that is subject to this authorization,

_____ Leave information your voice mail (including appointment reminders)

_____ Give information to spouse: _____

_____ Give information to the following person/s:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ Release Financial Information to the entities named above (including procedure estimates)

Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Center for Digestive Diseases and Cary Endoscopy, PC. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to disclosure by the recipient and may no longer be protected by Federal or State law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization.

This authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

_____ _____

Signature of Patient or Personal Representative Date

Description of Personal Representative's Authority (attach necessary documentation)

Center for Digestive Disease and Cary Endoscopy Center
1120 SE Cary Parkway Suite 204
Cary, NC 27518
919-854-0041

MEDICAL HISTORY REVIEW

Name: _____ DOB: _____ Primary Care Doctor: _____
Present Problem: _____Height: _____ Weight: _____
Allergies to Medications: _____

Allergy: ____ LATEX ____ Adhesive Tape ____ Peanuts ____ Eggs ____ Shellfish ____ Soy
____ Milk ____ Wheat

GENERAL:
Weight Loss: YES NO Amount: _____ Weight Gain: YES NO Amount: _____
Fever/Chills: YES NO When: _____ Lack of Energy: YES NO

GASTROENTEROLOGY:
Nausea/Vomiting: YES NO Loss of Appetite: YES NO
Gas/Bloating: YES NO Heartburn: YES NO
Hard Swallow/Choking: YES NO Solid: _____ Liquids: _____ When: _____
Abdominal Pain: YES NO Where: _____ When: _____ How Long: _____
Change in Bowel: YES NO Constipation: YES NO Laxative: _____
Diarrhea: YES NO Rectal Bleeding: YES NO
Ulcerative Colitis: YES NO Crohn's: YES NO
Diverticulosis: YES NO Diverticulitis: YES NO
Jaundice/Liver Disease: YES NO Hemorrhoids: YES NO
Other Stomach/Colon Problems: _____
Family Hx: Colon Cancer: YES NO Who: _____ Family Hx. Polyps YES NO Who: _____

CARDIOVASCULAR: **CURRENT CARDIOLOGIST: _____**

Aspirin/Dose: _____ **Personal Choice?** _____ ***OR*** Prescribed by: Dr._____
Blood Thinner: _____ Prescribed by Dr._____

Heart Attack: YES NO When: _____ Heart Surgery: YES NO When: _____
Chest Pain: YES NO When: _____ DVT/Blood Clot: YES NO Where: _____
Irregular Heart Beat: YES NO Stroke: YES NO When: _____
AFIB: YES NO Heart Murmur YES NO
High Blood Pressure: YES NO Mitral Valve: YES NO Antibiotic: _____
Congestive Heart Failure: YES NO High Cholesterol YES NO
Heart Cauterization: YES NO When: _____ Stents: YES NO Number: _____
Pacemaker: YES NO When: _____ Defibrillator: YES NO When: _____

Other Heart Conditions: _____

(Continued on next page or back of page)

RESPIRATORY: **PULMONOLOGIST**: _____

Asthma: YES NO How Often: _____ Inhalers: YES NO Last Used: _____
Short of Breath YES NO w/Exertion: _____ COPD: YES NO
Emphysema YES NO Sleep Apnea: YES NO CPAP: _____
Cough/Wheezing YES NO Oxygen Use: YES NO How Often: _____
Other Respiratory _____

RENAL: _____ NEPHROLOGIST: **_____** **NEUROLOGIST: _____**

Diabetic: YES NO Insulin: ___ Oral: ___ Seizures: YES NO Last Event: _____
Kidney Problems: YES NO Type:_____ Headaches: YES NO Migraines?: _____
Dialysis: YES NO When: _____ Brain Injury: YES NO When: _____
Urinary frequency: YES NO How Often_____ Memory Loss: YES NO
Blood in Urine: YES NO Poor Balance: YES NO
Urinary Urgency: YES NO How Often_____ Epilepsy: YES NO Last Event: _____
Prostate Problems: YES NO Type_____ Weakness: YES NO Where: _____
Prostate Cancer: YES NO Surgery_____ Nerve Disease: YES NO
Gout: YES NO Med? _____ Tingling/Numb: YES NO Where: _____

OTHER:

Sore Throat: YES NO When: _____ Sinus: YES NO
Glaucoma: YES NO Loss of Hearing: YES NO
Anxiety: YES NO Depression: YES NO
Bipolar YES NO Schizophrenia: YES NO
Thyroid: YES NO Type: _____ Are You Pregnant: YES NO LMP: _____
Joint Replacement YES NO Which: _____ When: _____
Alcohol: YES NO Drinks/week_____ Tobacco: YES NO Pack/day_____
Recreational Drugs: YES NO What Drug _____ How often_____
Hepatitis: YES NO Type_____ HIV: YES NO Anemia: YES NO
OTHER HEALTH PROBLEMS: _____
PROBLEMS WITH: IV's YES NO Why_____ ***OR*** **Anesthesia:** YES NO Why _____

SURGERIES/HOSPITALIZATION:

Abdominal surgeries/When: _____
Other Surgeries/When: _____
Major Hospitalizations/When: _____
COLONOSCOPY: DATE: _____RESULTS:_____DOCTOR:_____
DATE: _____RESULTS:_____DOCTOR:_____
EGD: DATE: _____RESULTS:_____DOCTOR:_____
DATE: _____RESULTS:_____DOCTOR:_____

Patient/Responsible Party Signature: _____ Date: _____
Relationship to Patient: _____
Nurse Signature: _____ Date:_____

MEDICATION LIST

PATIENT NAME: _____ DATE OF BIRTH: _____

Please list below: P**rescription medications**
Over-the-counter medications (vitamins, supplements, pain relievers, etc.)

MEDICATION NAME	**DOSAGE**	**WHEN DO YOU TAKE IT** (How many times a day / am or pm)

Patient/Responsible Party Signature: _____ Date: _____

Relationship to Patient: _____

Nurse Signature: _____ Date:_____

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THIS IS VERY IMPORTANT! PATIENTS PLEASE MAKE SURE THAT YOU READ AND UNDERSTAND BEFORE SIGNING!

Dear Patient,

We would like to take this opportunity to acquaint you with our office and billing procedures. It is our goal to satisfy you and make the financial aspects of your health care as convenient as possible. Therefore, as a courtesy to you, we file most insurance. We will need a photocopy of your insurance card in order to process your claim. Without your card you will be responsible for full payment at the time that services are rendered. If your plan requires an annual deductible, we will need you to bring an explanation of benefits statement/form from you insurance carrier that shows that the deductible has been met.

All patients who have insurance that requires an authorization (referral) are responsible for obtaining that authorization. When no authorization has been received prior to your appointment; you will be asked to either reschedule your appointment or be responsible for the full bill.

Copays or coinsurance will be due at the time services are rendered.

If you have a copay or coinsurance you will be expected to pay it at every office visit. If you are scheduled for a procedure we will be responsible for obtaining authorization if it is needed. We will call your insurance company prior to your procedure to find out ***approximately*** what you will owe. We will inform you of what this amount is as soon as we can and **you will be expected to pay it on the day of your procedure**. If this amount includes a deductible and you believe that you have already met it, you will need to bring an explanation of benefits statement/form from your insurance carrier that shows that the deductible has been met.

We require that you notify us twenty-four (24) hours in advance prior to any office cancellations, or forty-eight (48) hours in advance for a procedure cancellation or there may be a **$25.00** charge applied to the patient for the missed appointment or a **$50.00** charge for a missed procedure. The Physicians do reserve the right to cancel an appointment or procedure due to a conflict in scheduling.

Assignment of Benefits and Authorization for Release of Information

I authorize release of any information concerning my or my child's health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits directly to my physician. I am financially responsible for non-covered expenses.

We are committed to providing you with the best possible care. As a service to you, we will file your insurance claim with necessary information in a timely fashion. Any balances after insurance pays will be billed to you for payment.
Please remember that your contract is between you and your insurance company to provide reimbursement for medical care. We cannot be responsible for unwarranted delays by your insurance company or HMO. If your coverage is not what you expect, please discuss it with insurance company or employer.

Most insurance policies will not cover the entire expense for your care. Please pay your co-pay at time of check in. In most cases, you will be required to make a deposit at the time your surgery is scheduled. For your convenience, we accept cash, checks, and most major credit cards.

Acknowledgement of Receipt of Privacy Notice

I understand that my physician or staff may share my / my child's medical information for treatment, billing, and healthcare business purposes. I acknowledge that I have been given information that describes how my / my child's medical information is used and shared.

We thank you for the opportunity to serve you!

I have read, understand and accept the above policies.

_____	_____	_____
Patients Signature	Date	Date of Birth