Todays Date: ____/_____/_____

First Name: _____**Full Middle Name**: _____ **Last Name**_____

Date of Birth _____/_____/_____ **Social Security** _____-_____-_____ **Gender** ❑ Male ❑ Female

Mailing Address: _____

Street City State Zip

Phone Number (mark primary) ❑ Home_____ ❑ Cell_____ **Consent to Text** ❑ Yes ❑ No

***Is it OK to leave results or protected health information on your voicemail? ❑ Yes ❑ No

Marital Status ❑ Married ❑ Single ❑ Widowed ❑ Divorced **Advanced Directive** ❑ Yes ❑ No **Occupation:** _____

Preferred Language ❑ English ❑ Spanish ❑ Declined ❑ Other _____

Ethnicity ❑ Hispanic or Latino ❑ Non-Hispanic or Latino ❑Declined

Race ❑ American Indian/Alaskan Native ❑ Asian ❑ Black/African American ❑ Native Hawaiian/Other Pacific Islander ❑ White ❑ Other Race ❑ Declined

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PREFERRED PHARMACY INFORMATION: Pharmacy Name_____ **MEDICATIONS**

Pharmacy Phone_____ ***PLEASE PROVIDE LIST TO FRONT DESK***

I authorize GIHP to communicate electronically with my preferred pharmacy to obtain my prescription history. ❑ Yes ❑ No

EMERGENCY CONTACT: spouse, relative or friend living with you

Name: _____ Relationship: _____ Daytime Phone: _____

CIRCLE OF CARE: Primary Care Physician _____ Phone: _____

Referred by _____Phone: _____

Other Physicians involved in your care: _____ Phone:_____

_____ Phone: _____

Insurance/Billing Policy (please provide insurance card to front desk) **Are you Insured** ❑ Yes ❑ No

Primary Policy Holder Name: _____ DOB: _____ Relationship: _____

I certify that the above information is correct. I consent to be treated by the staff and providers of GIHP and its affiliates. I authorize payment of medical benefits to GIHP and its affiliates, and authorize them to release any medical information necessary to process claims. I understand that I am responsible for co-payments, deductibles, co-insurance and non-covered services. If I do not pay in accordance with the above policy and my account is sent to a collection agency, I agree to pay all costs of collection, including attorney fees.

Patient Signature_____ **Date**_____

HIPAA
Consent to Release Information

In the event I cannot be reached, I, _____, give permission for a representative from GIHP and its affiliates to share information regarding care or tests results with the individuals listed below. These individuals may also request protected health information on my behalf.

Name_____ Phone _____ Relationship_____

(spouse, friends, or family)

Name_____ Phone _____ Relationship_____

(spouse, friends, or family)

I recognize that GIHP and its affiliates may share my protected health information with other healthcare providers, including sensitive health information such as: HIV/AIDS information, substance abuse records, genetic testing information, and developmental disability records. This information may be shared with other healthcare providers via various methods, including but not limited to, fax or health information exchange.

NOTE: If you choose to opt out of having your information shared via health information exchange, you must request and complete an Opt-Out Form available at GIHP offices.

Patient/Authorized Representative Signature_____ **Date** _____

PATIENT PORTAL

Gastrointestinal Health Partners, PLLC offers secure, HIPAA compliant viewing of parts of your medical record and communication from our staff as a service to our patients. Secure messaging can be a valuable communications tool, but has certain risks. To manage these risks, we need to impose some conditions of participation. This form is intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation**. While this service is optional and not necessary to interact and communicate with our clinic, our practice would like to utilize this method as our primary source of notification to our patients. If you opt out of this service, please speak with the nurse regarding other methods of communication.**

You can view more clinic specific information or access the Patient Portal through our clinic web page at www.gihealthtn.com. Access to the secure portal is optional but highly recommended service. We reserve the right to suspend or terminate it at any time and for any reason. If we do suspend or terminate the service we will notify you as promptly as we reasonably can. You agree to not hold Gastrointestinal Health Partners, PLLC or any of its staff liable for network infractions beyond their control.

❑ I ACCEPT ❑ I DECLINE Print Name_____ Patient email_____

Patient Signature_____ Date_____

Authorization to Release Medical Information

(All sections must be completed if you have seen another provider for the reasons related to your visit today.)

Patient Name: _____ Date of Birth: _____

I hereby authorize the release of medical records from: (Doctor/Clinic) _____

Address_____

Phone_____ Fax_____

I hereby authorize the release of medical records to: Gastrointestinal Health Partners, PLLC.

Nashville: 615-649-9940 **Lebanon: 615-547-2334** **Fax: 1-877-759-6609**

Purpose of disclosure: ___continuation of care_____

The authorization will expire on: _____
(Date or event may not exceed one year)

This request and authorization applies to:

- All medical Records
- Health care information relating to the following treatment, condition, or dates of treatment: _____
- Specific records to be released (i.e., Labs, imaging reports, other): _____

If you DO NOT WANT certain portions of your medical records released, please initial the box for the information you do not want released. _____Substance abuse _____ Psychological or psychiatric treatment _____HIV/AIDS/STD

I understand I have the right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance before the notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-names office may not condition treatment on my signing of this authorization.

_____ _____ _____
Signature of Patient or Authorized Representative Relationship to patient Date Signed

Describe the reason(s) for your visit_____

ALLERGIES List any medication allergies: ❑ None _____

List any environmental or food allergies: ❑ No known environmental allergies ❑ No known food allergies

_____

Are you currently taking any of the following blood thinners? ❑ Coumadin ❑ Plavix ❑ Warfarin ❑ Xarelto ❑ Other_____

Prescribing MD: _____

Are you currently taking any of the following aspirin/NSAIDs? ❑ Advil ❑ Aleve ❑ BCPowder ❑ Goody's Powder ❑ Ibuprofen ❑ Naproxen

Vaccines : ❑ Hepatitis A ❑ Hepatitis B ❑ Pneumonia ❑ Flu ❑ TB year:_____

SOCIAL HISTORY Provide details regarding current and/or past use of the following:

Smoking Status ❑ Every Day ❑ Some Days ❑ Former ❑ Never

I.V. or Recreational Drugs ❑Yes ❑ No Usage _____

Tobacco (cigarettes, cigars, chewing tobacco) ❑ Yes ❑ No Usage_____

Alcohol (beer, wine, liquor) ❑ Yes ❑ No Usage _____

**Please note how many days in the past year have you had heavy drinking consumption based on your gender? Male _____Female: _____

FAMILY HISTORY (1ST degree relatives) Check all that apply.

CANCERS	Mom	Dad	Sister	Brother	Son	Daughter	Age at diagnosis
Breast							
Colon							
Esophagus							
Lung							
Pancreas							
Prostate							
Stomach							
Other: _____							

	Mom	Dad	Sister	Brother	Son	Daughter
Acid Reflux						
Barretts Esophagus						
Colon Polyps						
Crohn's Disease						
Liver Disease						
Malignant Hyperthermia						
Ulcerative Colitis						

PATIENT MEDICAL HISTORY

Check all that apply

❑Cirrhosis
❑Colon Polyps
❑Crohn's Disease
❑Diverticulitis/ Diverticulosis
❑GERD
❑Hepatitis B
❑Hepatitis C (HCV)
❑Hiatal Hernia
❑Irritable Bowel Syndrome
❑Liver Disease
❑Stomach/Intestinal Ulcers
❑Ulcerative Colitis
❑Anemia

❑Anxiety/Depression
❑Arthritis/Osteoarthritis
❑Asthma
❑Cancer: Type _____
❑Chronic Kidney Disease (CKD)
**Dialysis? YES____ NO ____
❑Congestive Heart Disease (CHF)
❑COPD/Emphysema
❑Coronary Artery Disease (CAD)
❑Diabetes
❑Glaucoma
❑HIV/AIDS
❑ High Cholesterol
❑Hypertension
❑Hypothyroidism

❑Malignant Hyperthermia
❑Migraines
❑Nerve/Muscle Disease
❑Obesity
❑Osteoporosis
❑Obstructive Sleep Apnea
Cpap/Bipap: YES____ NO ____
❑Pancreatitis
❑Seizures
❑TB
❑Other _____

CARDIAC

❑A Fib
❑Artificial Heart Valve
❑Blood clots
❑Myocardial Infarction/ Heart Attack

PATIENT MEDICAL HISTORY. Check all that apply

❑**Colon Surgery** _____
❑**Colonoscopy** _____
❑**Hemorrhoid Surgery** _____
❑**Gallbladder Surgery** _____
❑**Gastric Surgery** _____
❑**Liver Surgery** _____
❑**Nissen Fundoplication** _____

❑**Small Intestine Surgery** _____
❑**Upper Endoscopy (EGD)** _____
❑Appendectomy _____
❑Brain Surgery _____
❑Breast Surgery _____
❑CABG/Heart Surgery _____
❑Cosmetic Surgery _____

❑Defibrillator/Pacemaker _____
❑Hernia Surgery _____
❑Hysterectomy
Abdominal/Vaginal _____
❑Joint Replacement _____
❑Laparotomy _____
❑Obesity Surgery
Type, if known _____
❑Prostate Surgery _____
❑Spinal Surgery _____
❑Transplant Surgery _____
❑Tubal Ligation _____
❑Valve Replacement Surgery _____
❑Past Anesthesia Complications
_____

SYSTEMS REVIEW: Do you or have you experienced any of the following in the last 12 months?

CONSTITUTIONAL
❑Body Aches
❑Chills
❑Fatigue
❑Fever
❑Loss of Appetite
❑Malaise (feeling ill)
❑Night Sweats
❑Weight Gain
❑Weight Loss (dieting)

EYES
❑Blurred Vision
❑Visual Changes
❑None of the Above

EARS/NOSE/THROAT
❑Ear Pain/Ringing
❑Hearing Loss
❑Mouth Ulcers/Sores
❑Nose Bleeds
❑Problems with Gums/Teeth
❑Trouble Swallowing

CARDIOVASCULAR
❑Chest Pain
❑Leaky Heart Valves
❑Heart Murmur
❑Heart Racing/Skipping
❑High Blood Pressure
❑Palpitations

RESPIRATORY
❑Chronic Cough
❑Shortness of Breath
❑Wheezing or Asthma Symptoms

GASTROINTESTINAL
❑Abdominal Pain/Discomfort
❑Anal/Rectal Pain or Itching
❑Anal Spasm
❑Black Stool
❑Bloating/Belching/Gas
❑Change of Bowel Habit
❑Constipation
❑Diarrhea/Loose Stool
❑Difficulty in Swallowing
❑Heartburn/Esophageal Reflux
❑Hemorrhoids
❑Indigestion
❑Mucus in Stool
❑Nausea/Vomiting
❑Rectal Bleeding (in stool, commode, toilet paper)
❑Unintentional Weight Loss (not dieting)

GENITOURINARY
❑Are you pregnant?
❑Date of last period
❑Blood in Urine
❑Burning/Pain with Urination
❑Increased Frequency/During Night
❑Recent/Frequent Urinary Tract Infection
❑Kidney Stones

SKIN
❑Itching/Dry Skin
❑Jaundice (yellow eyes or skin)
❑Rashes, Bumps or Sores

NEUROLOGIC
❑Headaches
❑Dizziness/Vertigo
❑Head Trauma/Injury
❑Recent Numbness/Weakness
❑Seizures

MUSCULOSKELETAL
❑Back Pain
❑Decreased Range of Motion
❑Joint Pain/Arthritis
❑Problems Walking/Calf or Leg Pain

ENDOCRINE
❑Bruise easily
❑Excessive Thirst
❑Heat/Cold Intolerance
❑History of High or Low Blood Sugar

PSYCHIATRY
❑Anxiety
❑Changes in Sleep Pattern
❑Depression
❑Loss of memory

HEMATOLOGY/LYMPHATIC
❑Bleeding Problems
❑Enlarged Nodes/Swollen Glands
❑Excessive Bruising
❑History of Anemia

ALLERGY/IMMUNOLOGY
❑Seasonal Allergies

Name: DOB:

MEDICATIONS

List Current Medications (including herbal) and Dosage

List Current Medications (including herbal) and Dosage

Vitals: _____

Notes:

Pt Initial _____

Pt DOB __/___/___