Name _____DOB _____

1. Social history

Married____ Single____ Divorced___
Widow_____
Employment _____

How many children_____

2. GI Review of Systems

(Circle all that apply)

Abdominal pain Weight loss
Nausea/Vomiting Change in bowel habit
Trouble swallowing Atypical chest pain
Vomiting blood Black/bloody stool
Bloating chronic constipation
Diarrhea (less than 3 weeks)
Chronic Diarrhea Jaundice (yellow)
Anal pain hemorrhoids/fissure
Heartburn increased stress
New or worsen Asthma

3. Past medical History

(circle all that apply)

Asthma/COPD Diabetes
Angina/Myocardial infraction Gout
Ulcers Hyperlipidemia
Congestive Heart Failure Hypertension
Arthritis Thyroid Disease Anemia
Anxiety/Depression Renal/Kidney Disease
Liver Disease Hepatitis Stroke/TIA
Arrhythmias Cancer_____
Other_____

4. Endoscopy History

Last Colonoscopy_____
Where_____

Upper Endoscopy _____

5. Past Surgical History

Surgery _____Date_____

_____
_____
_____

6. Family History

(Circle all that apply)

Diabetes Colitis Heart Disease

Hypertension Thyroid Disease

Colon Cancer (who) _____

Other Cancer (who & What type)

_____

7. Habits

Tobacco: Yes____ No___ Quit_____
Packs daily _____ how long _____

Alcohol: Type_____

Daily_____ Occasionally_____

Socially_____Quit_____

Coffee: cups daily _____

Other Caffeine's _____

Recreational drugs: _____

Current_____past_____quit_____

8. Allergies

_____
_____
_____

Physician HealthCare Network

PATIENT DEMOGRAPHICS/CONTACT INFORMATION

LAST NAME_____ FIRST NAME_____ MI _____

PREFERRED NAME/NICKNAME_____ SEX_____ DOB _____ SSN_____

ADDRESS _____ CITY, STATE_____ ZIP CODE_____

HOME PHONE_____ MOBILE PHONE_____ CONSENT TO RECEIVE TEXT MSGS? [redacted]

PREFERRED CONTACT METHOD: HOME PHONE OR MOBILE PHONE EMAIL ADDRESS:_____

PRIMARY CARE PHYSICIAN:_____ PHONE:_____

Race: African American American Indian Asian White Hispanic/Latino Multi-Racial Other Decline

Ethnicity: Hispanic/Latino Non-Hispanic/Latino Decline

Language: English Indian Spanish Russian Other

MARITAL STATUS: SINGLE MARRIED DIVORCED SEPARATED

GUARDIANSHIP INFORMATION:

IS PATIENT A MINOR? YES NO (If yes, please provide guardianship information below)

IF PATIENT IS OVER 18 YEARS OF AGE, DOES THE PATIENT HAVE A GUARDIAN? YES NO (If yes, please provide guardianship information below) *IF PATIENT IS OVER 18 AND HAS A LEGAL GUARDIAN, PLEASE PROVIDE PROOF OF GUARDIANSHIP*

GUARDIAN NAME:_____ PHONE:_____

ADDRESS:_____ CITY, STATE, ZIP _____

EMERGENCY CONTACT:

NAME:_____ RELATIONSHIP:_____ PHONE:_____

EMPLOYMENT:

EMPLOYER:_____ OCCUPATION:_____

ADDRESS:_____ CITY, STATE, ZIP:_____

PHONE:_____

_____

NEXT OF KIN:_____ RELATIONSHIP:_____ PHONE:_____

INSURANCE SUBSCRIBER-

INSURANCE SUBSCRIBER:_____ RELATIONSHIP:_____

SSN:_____ SUBSCRIBER DOB: _____

ADDRESS:_____ CITY, STATE, ZIP:_____

PHONE:_____

WE ARE AN E-PRESCRIBING OFFICE, NON-CONTROLLED PRESCRIPTIONS WILL BE SENT TO THE PHARMACY OF YOUR CHOICE. FOR PRESCRIPTION REFILLS, PLEASE CONTACT YOUR PHARMACY.

PHARMACY OF CHOICE:_____ LOCATION:_____

Physician HealthCare Network

ASSIGNMENT OF BENEFITS: I authorize my/my child's physician to release information from my/my child's medical record to my/my child's insurance carrier(s), or government agency for the processing of claims for medical benefits. I request that my/my child's insurance company(s) honor my/my child's assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my/my child's physician, on my behalf.

INITIALS: _____

CONSENT FOR TREATMENT: I voluntarily consent to my/my child's treatment; including physician examinations, all procedures and tests such as x-rays, blood tests, and medical treatment by the staff of Physician Healthcare Network. No guarantees have been made to the patient regarding the results of such care and treatment which are hereby authorized.

INITIALS: _____

PATIENT FINANCIAL POLICY: I understand all accounts are the full responsibility of the patient and/or the patient's responsible party/guarantor. Please remember – your medical insurance policy is a contract between you and your insurance company. We cannot be a party to that contract. Due to the policy between patient and insurance company, all copays are due at the time of service.

INITIALS: _____

PRIVACY PRACTICES (HIPAA): I acknowledge that I have been offered a copy of Physician Healthcare Network's Notice of Privacy Practices. Accepted ○ Declined ○

RELEASE OF INFORMATION: I give my consent and authorization for the medical or billing staff of Physician Healthcare Network to leave protected health care information about me or my child on my answering machine or voicemail via the telephone number I have listed below. I also consent to receive automated calls via

Check all that apply– phone____, voicemail____, text message____, email____

NUMBER_____INITIALS:_____

PROTECTED INFORMATION: My protected health information regarding me or my child may be shared with the following individuals:

NAME_____ RELATIONSHIP_____

NAME:_____ RELATIONSHIP_____

NAME:_____ RELATIONSHIP_____

INITIALS: _____

E-PRESCRIBING MEDICATIONS: I authorize my physician to refill my or my child's medications through a computerized system. I also authorize my physician to obtain my or my child's medical history from my pharmacy, health plan, or other healthcare providers.

PHARMACY:_____INITIALS:_____

SIGNATURE:_____ DATE:_____

Printed name:_____Relationship to patient:_____

Physician
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Patient-Provider Partnership Agreement

The health and wellness of our patients is a top concern of Physician Healthcare Network, PC. Providing the best possible care to every patient is our primary goal. The only way we can meet this goal is if we, Physician Healthcare Network and you, the patient, work together. This concept is called:

Patient Centered Medical Home

*Patient's Responsibilities:

- Ask questions, share your feelings and be part of your care
- Be honest about your history, symptoms, and other important information about your health
- Tell your provider about any changes in your health and well-being
- Follow your provider's instructions, including taking your medication(s) as directed
- Make healthy decisions about your daily habits and lifestyle
- Prepare for and keep scheduled visits or reschedule your visit in advance whenever possible
- Call your provider first with all problems, unless it is a medical emergency
- Leave every visit with a clear understanding of your provider's expectations, treatment goals, and future plans
- For coordination of care purposes you authorize your provider to exchange your medical information (written or electronic), when appropriate, with other providers involved in your care (i.e. admissions, discharges and transferred to/from hospital based care settings, specialist referrals or any other healthcare encounters outside of your provider's office.)

*Provider's Responsibilities:

- Explain diseases, treatments, and results in an easy-to-understand way
- Listen to your feelings and questions; help you make the best decisions about your care
- Keep treatments, discussions, and records private
- Provide 24 hours access to medical care and same day appointments, whenever possible
- To care for you to the best of my abilities based on my understanding of current medical methods available
- Give my patients clear instructions about medications and other treatments
- Send my patients (along with appropriate medical information) to trusted experts, when needed
- End every visit with clear instructions about expectations, treatment goals and future plans

_____ _____

Patient/Guardian Signature Today's Date

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CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment, you provide more than 24 hour notice. This will allow for another patient who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made with less than a 24 hour notice, we are unable to offer that slot to other patients.

Office appointments which are cancelled with less than a 24 hour notification may be subject to a $25.00 cancellation fee. Procedure cancellations require 5-7 business day advance notice and without notification they may be subject to a $100.00 cancellation fee.

Patients who do not show for their appointment without a call to cancel an office appointment or procedure will be considered as a NO SHOW. Patients may also be subject to a $50.00 fee for office appointment NO SHOW or $100.00 procedure NO SHOW fee.

NO SHOWS:

First occurrence: Patient will be sent a letter or called. No fine is assessed.

Second occurrence: Patient will be charged a $50 fee (office visit) or $100 fee (procedure)

Third occurrence: Patient will be discharged from the practice.

The cancellation and NO SHOW fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that special, unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

Our practice firmly believes that good physician/patient relationships are based upon understanding and good communication. Questions about cancellation and NO SHOW fees should be directed to the office manager.

Please sign that you have read, understand and agree to this cancellation and NO SHOW policy.

_____ Date of Birth _____

Patient Name (Please Print)

_____ _____

Signature of Patient or Patient Representative Date