Advanced Gastroenterology & Endoscopy Center

PATIENT QUESTIONNAIRE

Date: _____ **Family Physician:** _____

Patient's Name: _____ _____

Address: _____

e-mail address: _____

Ethnicity: Hispanic/Latino—other

Race: White Black Other Asian Hispanic North American

☐ **I understand that my e-mail will only be used for educational information. Your e-mail will never be shared.**

Telephone Number (Home): _____ **(Work):** _____ **(Cell):** _____

Sex: ☐ **Female** ☐ **Male** **Date of Birth:** _____

Emergency Contact: _____ **Phone # and Relationship:** _____

Guarantor: _____ **Date of Birth:**

Primary Insurance: _____ **Policy Number:** _____

Effective Date of Coverage: _____ **Group/Plan Number:** _____

Address: _____ **Phone #:** _____

Secondary Insurance: _____ **Policy Number:** _____

Address: _____ **Phone #:** _____

Information provided by: _____

Date: _____

INFORMATION verified by AGI employee: _____ **Date:** _____

PREVIOUS FHCP MEMBER: ☐ **YES** ☐ **NO** **If yes, Medical Record Numbe** _____

Physician scheduled to see: _____ **Appt. Date & Time:** _____

Rev 9/26/18

Advanced Gastroenterology & Endoscopy Center

Name: _____ Date: _____

DOB: _____ Age: _____ MR#: _____

_____

Allergies: No _____ Or Yes _____ and to what: _____
(If "Yes", please list above)

- ☐ DIABETES
- ☐ ASTHMA
- ☐ EMPHYSEMA
- ☐ COPD
- ☐ BRONCHITIS
- ☐ HEART ATTACK
- ☐ CONGESTIVE HEART FAILURE
- ☐ ATRIAL FIBRILLATION
- ☐ ANGINA / ASVD
- ☐ STROKE
- ☐ MIGRAINES
- ☐ RENAL INSUFFICIENCY
- ☐ GALLSTONES
- ☐ PANCREATITIS
- ☐ CIRRHOSIS
- ☐ VIRAL HEPATITIS
- ☐ AUTOIMMUNE HEPATITIS
- ☐ HEMOCHROMATOSIS
- ☐ ALCOHOLISM
- ☐ STOMACH ULCERS P PUD
- ☐ HERNIAS
- ☐ BOWEL OBSTRUCTION
- ☐ IRRITABLE BOWEL / IBS
- ☐ ESOPHAGITIS
- ☐ ESOPHAGEAL STRICTURE
- ☐ GERD
- ☐ COLON POLYPS
- ☐ DIVERTCULOSIS
- ☐ HEMORRHOIDS
- ☐ ULCERATIVE COLITIS
- ☐ CHRON'S DISEASE
- ☐ HIGH BLOOD PRESSURE
- ☐ COLON CANCER
- ☐ BREAST CANCER
- ☐ UTERINE CANCER
- ☐ OVARIAN CANCER
- ☐ OTHER CANCER
- ☐ _____
- ☐ HEPATITIS
- ☐ BLOOD DISORDER
- ☐ LIVER PROBLEM
- ☐ DEPRESSION
- ☐ SEIZURE DISORDER

SOCIAL HISTORY

- ☐ DO YOU SMOKE
- ☐ DO YOU DRINK (ALCOHOL)
- ☐ DO YOU USE DRUGS

GI PROCEDURE HISTORY

- ☐ UPPER ENDOSCOPY / EGD
- ☐ COLONOSCOPY
- ☐ ERCP

SURGICAL HISTORY

- ☐ CHOLECYSTECTOMY (Gallbladder)
- ☐ TONSILLECTOMY
- ☐ HYSTERECTOMY
- ☐ CABG / ANGIOPLASTY
- ☐ APPENDECTOMY
- ☐ PROSTATECTOMY
- ☐ GASTRECTOMY
- ☐ JOINT REPLACEMENT
- ☐ TUBAL LIGATION
- ☐ BOWEL SURGERY
- ☐ OTHER SURGERY: list below
- ☐ _____
- ☐ _____
- ☐ _____

FAMILY Hx / RELATIONSHIP

- ☐ HIGH BLOOD PRESSURE
- ☐ HEART DISEASE
- ☐ DIABETES
- ☐ GALL BLADDER
- ☐ COLON CANCER
- ☐ COLON POLYPS
- ☐ ULCERS
- ☐ LIVER DISEASE
- ☐ OTHER PROBLEMS: list below
- ☐ _____
- ☐ _____
- ☐ _____

Continued on next page . . .

Advanced Gastroenterology & Endoscopy Center

Name: _____ Date: _____

DOB: _____ Age: _____ MR#: _____

_____

Place an X if you have or have had the symptom for the past 12 months:

- ☐ FEVER
- ☐ CHILLS
- ☐ SWEATS
- ☐ WEIGHT LOSS
- ☐ CHANGE IN APPETITE
- ☐ EYE DISORDER
- ☐ NECK PROBLEMS
- ☐ HOARSENESS
- ☐ COUGH
- ☐ CHEST PAIN
- ☐ IRREGULAR HEART
- ☐ PALPITATIONS
- ☐ HEART PROBLEMS
- ☐ POOR CIRCULATION
- ☐ HIGH BLOOD PRESSURE
- ☐ HEART MURMUR
- ☐ SWELLING OF LEGS
- ☐ NAUSEA
- ☐ VOMITING
- ☐ DIARRHEA
- ☐ CONSTIPATION
- ☐ ABDOMINAL PAIN
- ☐ HEART BURN / REFFLUX
- ☐ JAUNDICE / YELLOW SKIN
- ☐ BLOATING
- ☐ LIVER PROBLEMS
- ☐ STOMACH PROBLEMS
- ☐ INTESTINE PROBLEMS
- ☐ COLON PROBLEMS
- ☐ PAIN ON URINATION
- ☐ DIFFICULTY URINATING
- ☐ BLOOD IN URINE
- ☐ KIDNEY PROBLEMS
- ☐ PROSTATE PROBLEMS
- ☐ BLOOD DISORDER
- ☐ BLEEDING DISORDER
- ☐ ANEMIA
- ☐ BLOOD TRANSFUSION
- ☐ SKIN RASH
- ☐ ITCH
- ☐ HEADACHE
- ☐ DIZZINESS
- ☐ DEPRESSION
- ☐ ANXIETY
- ☐ SEIZURE DISORDER
- ☐ OTHER SYMPTOMS:
- ☐ DIFFICULTY SWALLOWING
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Medical Office
Financial Policy

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy that we require you to read and sign prior to any treatment. In addition, all patients must complete our attached information and insurance form before seeing the doctor.

Advanced Gastroenterology Centers Medical Billing Department is responsible for processing the billing for medical services rendered to you. If you have a balance due for medical services rendered, you will receive a statement from Advanced Gastroenterology Centers.

If you do not have insurance or do not want us to submit your charges to your insurance company, full payment is due at time of service. We accept cash, checks, Visa/MasterCard and American Express. There will be a $25 charge for each returned check. Balances not paid within 60 days from the date of service may be turned over to a collection agency.

Regarding your insurance:

If the physician you are seeing is a participating provider under your insurance plan and if the services you are receiving are expected to be covered expenses, we will gladly file your insurance claim for you. You will need to present your current insurance card and provide any additional information that may be necessary to file your claim. **You will be required to pay the estimated portion of the bill that you will be responsible for at the time of service**. Upon receipt of remittance from your insurance company, the remaining account balance will be transferred to your responsibility. You will receive a statement at that point detailing the charges due. This statement balance will be due immediately. Balances that are not paid within 60 days from the statement date may be forwarded to collection. Please be aware that some, and perhaps all, of the services provided may be non-covered services and are not considered reasonable and necessary under the Medicare program and/or other medical insurance.

We are committed to providing the best treatment for our patients and our charges are based on what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Please give at least 24 hours advance notice when canceling or changing appointments. Failure to do so will result in you being charged $75.00 for the missed appointment.

Thank you for understanding our financial policy. If you have any questions or concerns, please speak with a member of our staff or contact the billing office at 763-4920.

I have read the financial policy and understand and agree to this financial policy.

_____ _____

Signature of Patient or Responsible Party Date

CONSENT TO CARE: I hereby authorize and consent to care by the physicians of Advanced Gastroenterology including but not limited to any diagnostic testing, examination, diagnostic procedures, surgical and medical treatment or any other care which the physicians deem necessary to my health and well being.

I acknowledge that no guarantees have been made to me with regard to this care.

CONSENT TO ASSIGNMENT OF BENEFITS AND GUARANTEE OF PAYMENTS: I request that payment of any and all insurance payments due on behalf for services rendered by the physicians of Advanced Gastroenterology be made directly to them or their designee.

I further authorize Advanced Gastroenterology to submit Insurance Claims for payment on my behalf. I authorize the release of medical or other intermediaries for this or any future claims.

I understand that I may receive billings from outside facilities and laboratories. I understand that I am responsible for and agree to pay charges that are not paid or covered by my Insurance Plan. I know and understand that I am ultimately responsible for any charges for professional services I have received.

I have read all of the information on this form and have answered all the questions asked. I acknowledge that all information provided by myself or my responsible party is true and correct.

Written consent must be given if any information is to be provided to anyone other than the patient. This includes spouses and children of patients.

Verbal Information regarding my condition may be given (for 1 year from date below) to:

Name: _____ Relationship: _____

Signature: _____ Date: _____

If this consent has been signed by anyone other than the patient, please state the reason the patient was unable to sign. _____

Relationship to patient: _____

Witness: _____