PATIENT INFORMATION SHEET - FAYETTEVILLE GASTROENTEROLOGY ASSOCIATES

PLEASE PRINT INFORMATION		**TODAY'S DATE**
Last Name	First Name	Middle Initial
Address		Apt #:
ZIP Code	City	State
Primary Phone number ( ) -	Secondary Phone number ( ) -	
Email Address		
Social Security Number	☐ Male	☐ Female
Date of Birth (MM/DD/YYYY)		

Race	☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ White/Caucasian ☐ Native Hawaiian
	☐ Unreported/Declined to report
Ethnicity	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient declined or Unavailable
Language	☐ English ☐ Spanish ☐ Other: ________________________

Emergency Contact Name	Relationship to patient
Emergency Contact Phone Number	
Primary Care Physician (Family Doctor) Name	
Referring Physician Name (If other than Primary Care Physician)	

Name of Health Insurance	Relationship to Patient	☐ Self ☐ Spouse ☐ Child ☐ Other
Policy Holder Name	Policy Holder Date of Birth	
Policy Number:	Group Number:	Tricare Insurance Only - Sponsor SSN#
Name of Secondary Insurance	Relationship to Patient	☐ Self ☐ Spouse ☐ Child ☐ Other
Policy Holder Name	Policy Holder Date of Birth	
Policy Number:	Group Number:	Tricare Insurance Only - Sponsor SSN#

ALL INSURANCE INFORMATION MUST BE COMPLETE AND ACCURATE

Missing or inaccurate information will result in non-payment from your insurance company
Primary and secondary insurances will be billed as a courtesy by this office. Payment of benefits will be made to Fayetteville Gastroenterology Associates, P.A. for services rendered. Should your insurance company refuse payment, you will be notified. Patients notified of non-payment are expected to contact their insurance company to resolve any problems.

YOU MUST BRING YOUR MOST CURRENT INSURANCE CARD AND PHOTO ID TO EVERY APPOINTMENT

I UNDERSTAND THAT I WILL PAY ANY DEDUCTIBLE AND/OR CO-PAYMENT AT THE TIME OF SERVICE
YOUR INSURANCE COMPANY DETERMINES THIS AMOUNT.

PATIENT/RESPONSIBLE PARTY SIGNATURE: ____ DATE: ______________________

(Internal Info Only) Verified by:

FAYETTEVILLE GASTROENTEROLOGY ASSOCIATES, PA
2041 Valleygate Dr.
Fayetteville, NC 28304
Phone: (910) 323-5203 Fax: (910) 323-3650

PATIENT INTERVIEW FORM

FIRST NAME: ______________________________ **LAST NAME:** __________________________________

DATE OF BIRTH:________ / _________ /__________ **AGE:** ________ **Referring Physician:** ____________________

WHAT IS THE MAIN REASON FOR YOUR VISIT TO THE PHYSICIAN TODAY? ___________________________________

CURRENT MEDICATIONS: None ☐
Do you take any Prescription blood thinner medication? ☐ Yes ☐ No **Herbs/Vitamins?** ☐ Yes ☐ No

Please List Medications including dose and frequency : ____
____
____
____

Allergies: ☐ Patient has no known allergies ☐ Patient has no known drug allergies

Non-Medication Allergies:	☐ Latex	☐ Shellfish	☐ Eggs	☐ Other:______________________		
Antibiotic Allergies:	☐ Cipro	☐ Pencillin	☐ Flagyl	☐ Sulfa Drugs	☐ Erythroycin	☐ Levaquin
Other Medication Allergies:	☐ Aspirin	☐ Codeine	☐ Iodine/Contrast dye		☐ Other: ______________________	

PAST OR PRESENT MEDICAL CONDITIONS NONE: ☐

Gastrointestinal:	☐ Gastroesophageal reflux		☐ Duodenal Ulcer	
			☐ Hepatitis _____	☐ Colorectal Cancer
	☐ Stomach Ulcer	☐ Cirrhosis	☐ Pancreatitis	☐ Hiatal hernia
	☐ Gallstones	☐ Crohn's	☐ Colon polyps	☐ Fatty Liver
Cardiology:	☐ Atrial fibrillation	☐ Stroke	☐ Congestive heart failure	
	☐ Heart Attack (MI)	☐ Coronary artery disease	☐ High blood pressure	
Cancer:	☐ Breast cancer	☐ Uterine cancer	☐ Other: ______________________	
	☐ Ovarian cancer	☐ Prostate cancer		
Pulmonary:	☐ Emphysema	☐ Asthma	☐ COPD	
Other:	☐ Arthritis	☐ Diabetes type I	☐ On Dialysis (renal failure)	☐ Kidney stones
	☐ Seizures	☐ Diabetes type II	☐ Hyperthyroidism	☐ Sleep Apnea
	☐ Migraines	☐ High cholesterol	☐ Hypothyroidism	☐ Other: ___________

PREVIOUS PROCEDURES None ☐

☐ Pacemaker	Year: ______	☐ Bowel obstruction surgery	Year: ______	☐ Tubal pregnancy Surgery	Year: _____
☐ Defibrillator	Year: ______	☐ Gastric bypass surgery	Year: ______	☐ Appendectomy	Year: ______
☐ Coronary stent/angioplasty	Year: ______	☐ Gallbladder surgery	Year: ______	☐ Abdominoplasty	Year: ______
☐ Colon surgery	Year: ______	☐ Laparoscopy	Year: ______	☐ Hysterectomy	Year: ______
☐ Stomach ulcer surgery	Year: ______	☐ Tubal ligation	Year: ______	☐ Surgery, other	Year: ______

DIAGNOSTIC STUDIES/TESTS NONE: ☐

☐ Endoscopy (EGD)	Year: ______	☐ Gallbladder ultrasound	Year: ______	☐ Capsule endoscopy	Year: ______
☐ Colonoscopy	Year: ______	☐ HIDA scan	Year: ______	☐ MRI of:___________	Year: ______
☐ Upper GI X-ray	Year: ______	☐ CT abdomen	Year: ______	☐ ERCP	Year: ______
☐ Barium enema	Year: ______	☐ Abdominal ultrasound	Year: ______	☐ Other: ___________	Year: ______

PLEASE COMPLETE BACK OF THIS FORM

FIRST NAME: ________________________ **LAST NAME:** ____________________________ **DOB:** _____/_____ / _______

SOCIAL HISTORY Occupation: ____________________________ Number of children: _______________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Alcohol: ☐ NONE ☐ Beer Quantity: _________ Number: ________ Frequency: ____________

☐ Wine Quantity: _________ Number: ________ Frequency: ____________

☐ Liquor Quantity: _________ Number: ________ Frequency: ____________

Caffeine: ☐ None ☐ Coffee ☐ Tea ☐ Soda ☐ Energy Drink ☐ Other: ___________

Tobacco: ☐ Current every day smoker ☐ Former smoker

☐ Current some day smoker ☐ Never smoked

Type of tobacco used: ________________ Started: ________ Quit: ________ Quantity: _________ Frequency:_________

Drug Use: ☐ None ☐ IV Drug use ☐ Illegal drug use Quantity: ______ Number: ______ Frequency: ______

FAMILY MEDICAL HISTORY No knowledge of family history: ☐ Adopted: ☐

Diagnoses:	Mother	Father	Sister	Brother		Mother	Father	Sister	Brother
Colon Cancer	☐	☐	☐	☐	Gallstones	☐	☐	☐	☐
Colon Polyp	☐	☐	☐	☐	Cirrhosis	☐	☐	☐	☐
Esophageal Cancer	☐	☐	☐	☐	Pancreatitis	☐	☐	☐	☐
Pancreatic Cancer	☐	☐	☐	☐	Bleeding Disorder	☐	☐	☐	☐
Ulcerative Colitis	☐	☐	☐	☐	Uterine Cancer	☐		☐	
Crohn's Disease	☐	☐	☐	☐	Ovarian Cancer	☐		☐	
Stomach Cancer	☐	☐	☐	☐	Other Cancer:	☐	☐	☐	☐
Stomach Ulcer	☐	☐	☐	☐		☐	☐	☐	☐

REVIEW OF SYSTEMS:

Gastrointestinal: None: ☐

Heartburn ☐ Yes ☐ No

Difficulty swallowing ☐ Yes ☐ No

Rectal bleeding ☐ Yes ☐ No

Cardiovascular: None: ☐

Chest pain ☐ Yes ☐ No

Palpitations ☐ Yes ☐ No

Constitutional: None: ☐

Fever ☐ Yes ☐ No

Weight loss ☐ Yes ☐ No

ENMT: None: ☐

Sore Throat ☐ Yes ☐ No

Nose bleed ☐ Yes ☐ No

Genitourinary: None: ☐

Painful urination ☐ Yes ☐ No

Blood in urine ☐ Yes ☐ No

Hematologic/Lymphatic: None ☐

Easy bruising ☐ Yes ☐ No

Prolonged bleeding ☐ Yes ☐ No

Integumentary: None: ☐

Skin lesions ☐ Yes ☐ No

Rashes ☐ Yes ☐ No

Neurological: None: ☐

Dizziness ☐ Yes ☐ No

Focal weakness ☐ Yes ☐ No

Psychiatric: None: ☐

Anxiety ☐ Yes ☐ No

Nervousness ☐ Yes ☐ No

Respiratory: None: ☐

Cough ☐ Yes ☐ No

Shortness breath ☐ Yes ☐ No

I AM INTERESTED IN BEING CONTACTED REGARDING CLINICAL TRIALS FOR DISEASES OF THE GASTROINTESTINAL TRACT ☐ **Yes** ☐ **No**

PHARMACY NAME: ___________________________________ **PHARMACY LOCATION:** ___________________________