CarolinaDigestiveDiseases
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Patient Information

*****Please complete and bring with you to your appointment*****

Name _____ Today's Date _____

DOB _____ SSN _____

Address _____ Home # _____

City _____ Work # _____

County _____ State_____ Zip _____ Cell # _____

Email Address _____ **May we contact you by email?** Yes No

Race _____ Ethnicity: (*circle one*) Hispanic Non-Hispanic

Male or Female (circle one) Marital Status: M S D W

Emergency contact _____ Emergency phone# _____

Emergency contact's relation _____

Primary Care Physician _____

Referring MD for today's visit _____

Pharmacy _____ Pharmacy Location _____

Insurance Information

How do you intend to pay for today's visit? Cash / Check / Visa / MC / Insurance

Primary Insurance	Secondary Insurance
Insured By: Self / Spouse / Parent	Insured By: Self / Spouse / Parent
Insurance Name:	Insurance Name:

Patient Signature _____ Date _____

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Practice Policies

To ensure a pleasant and efficient relationship between CAROLINA DIGESTIVE DISEASES and YOU, we urge you to read our clinic policy carefully and sign at the bottom. A copy will be provided to you upon request.

GENERAL POLICY

1. Be prepared to pay a Co-Pay or payment at time of visit. You must present your insurance card at EACH visit!
2. As a patient of our office, you authorize the use and disclosure of your health information for the purposes of treatment, payment and healthcare operations. You also give consent for the healthcare providers of Carolina Digestive Diseases, PA to evaluate and render medical treatment.
3. By consenting to being seen in our office, you authorize your insurance benefits to be made payable directly to Carolina Digestive Diseases, PA , realizing that you are responsible for payment of any non-covered service

APPOINTMENT POLICY

1. Patients with scheduled appointments will be seen in order of appointment times.
2. A 24-hr Cancellation Notice is required for all procedure appointments, otherwise a $75 cancellation fee will be billed to you.
3. For "No-Show" appointments, a $75 fee will be billed to you.
4. Patients arriving 15 minutes or more late for their appointment may either wait to be worked back into the schedule or may reschedule to a different date.

PRESCRIPTION REFILL POLICY

1. Please allow 48 hours for a prescription refill to be authorized. Therefore, please do not let your medicine run out before requesting a refill. After 48 hours, please check with your pharmacy to verify the RX has been called in.
2. To expedite your request, please contact your pharmacy, who in turn will send us an electronic request for your refill. Please be advised that compliance with your recommended medical treatment is required to continue to receive medication refills.
3. Refill requests received after 4:00 PM are handled on the next business day.

TELEPHONE MESSAGE and PATIENT PORTAL POLICY

1. Please allow 48 hours for the nurse to return any non-urgent telephone messages or portal messages.
2. To facilitate a prompt response, please state/explain the reason for your call/message.
3. For any life threatening emergency or urgent matter, please call 911. DO NOT use the portal for emergent needs!!

MEDICAL LEAVE/DISABILITY FORMS

Carolina Digestive Diseases, PA charges $20.00 for any forms requested to be filled out for any medical leave or for disability requests. Forms dropped off will not be completed until fee is paid. This fee must be paid in cash only, no credit/debit card payments.

RETURNED CHECK POLICY

Fee $35.00

PRIVACY POLICY

Carolina Digestive Diseases, PA adheres to HIPAA and protection of all patient information. Your signature below indicates that you have received a copy of our Notice of Privacy Practices and HIPAA Policy.

PATIENT RIGHTS & RESPONSIBILITIES

Your signature below indicates that you have been given information on our policy of Patient Rights & Responsibilities.

I have read and understand the above policies and agree to abide by their terms.

Name of Patient: _____ Date:_____

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Date _____ Patient Name _____ DOB _____

Family/Social History

Have you ever had a blood transfusion? Y or N
If yes, Date _____ and # Units _____

Do you smoke? Y or N If quit, date _____
____ # packs per day for ____ years

Do you drink alcohol?(circle) Beer Wine Liquor
How many drinks per week?_____

Do you or have you used illegal drugs? Y or N

Do you have children? Y or N ____ how many?

Occupation _____

Who do you live with?_____

Father's age _____ or age at death _____
Cause of death _____
Health Problems _____
Mother's age _____ or age at death _____
Cause of death _____
Health Problems _____
Brothers/Sisters Age Health Problems Age at Death
_____
_____
_____

Procedures/Surgical History

Type of Surgery/Procedure Date

_____
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Allergies:

_____
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Medications

Please list all medications you are currently taking, including over the counter and herbal remedies.

Medication Dose/Frequency

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Date:_____ **Pt Name**_____ **DOB:**_____

Past Medical History

Please circle if you have been diagnosed with any of the following:

Colon Cancer		Artificial/Mechanical Heart Valve	†	Stroke	
Throat/Stomach Cancer		Joint Replacement		High Cholesterol	
Liver/Pancreatic Cancer		Hepatitis		Emphysema	
Breast Cancer		Kidney Stones	†	Pneumonia	
Lung Cancer		Blood Clots		Osteoporosis	
Cancer-Other		Sexually Transmitted Diseases		Lupus	
HIV/AIDS	†	Asthma	†	Liver Disease	
Crohn's/Ulcerative Colitis		Diabetes		Bleeding Problems	
Blood Transfusions	†	Thyroid Diseases	†	Tuberculosis	
High Blood Pressure	†	Psychiatric Problems			
Heart Problems/Irregular Heartbeat					

Review of Systems

Please circle or fill in any of the symptoms below which you have experienced within the past 3 months:

Allergic/ Immunologic — **No Problem** or HIV exposure, persistent infections, strong allergic reactions or urticaria
Other _____

Cardio-Vascular: — **No Problem** or Chest pain, irregular heartbeat, leg swelling, orthopnea, palpitations, syncope
Other_____

Constitutional: — **No Problem** or Weight gain, weight loss, fever, weakness, fatigue, headaches, loss of appetite, sweats
Other_____

Ears/Nose/ Mouth/Throat: — **No Problem** or Hoarseness, difficulty swallowing, sinus problems, dizziness, ear pain, sore throat
Other_____

Endocrine: — **No Problem** or Excessive thirst, hair loss, heat intolerance
Other_____

Eyes: — **No Problem** or Blurred vision, double vision
Other_____

Gastro-Intestinal: — **No Problem** or Abdominal pain, abdominal swelling, change in bowel habits, colon polyps, constipation, diarrhea, gas, gastric polyps, h pylori, heartburn, hemorrhoids, hiatal hernia, nausea, rectal bleeding, stomach cramps, ulcers, vomiting
Other_____

Genitourinary: — **No Problem** or Dark urine, dysuria, decreased urine flow, frequent UTI's, hematuria, impotence, difficulty urinating
Other_____

Hematological/ Lymphatic: — **No Problem** or Swollen lymph nodes, easily bruises, prolonged bleeding, anemia, bleeding gums
Other_____

Skin: — **No Problem** or Allergies, dryness, itching, jaundice, rashes
Other_____

Musculo-Skeletal: — **No Problem** or Arthritis, back pain, gout, joint deformity, joint pain
Other_____

Neurological: — **No Problem** or Fainting, headaches, migraines, numbness or tingling, seizures, tremors, vertigo
Other_____

Psychiatric: — **No Problem** or Anxiety, depression, difficulty sleeping, hallucinations, nervousness, panic attacks, paranoia
Other _____

Respiratory: — **No Problem** or Asthma, cough, dyspnea, hemoptysis, wheezing
Other_____