Gastroenterology Group of Rochester, LLP

For Office Use Only:		
Rhio	Yes	No
SureScripts	Yes	No

Name _____ DOB _____ Age _____ Today's Date _____

Referring MD _____ PCP _____ OB/GYN _____ Hgt _____ Wgt _____

Pharmacy: _____ Pharmacy Address: _____

Reason for visit: (circle all that apply or note reason in "other") Screening Colonoscopy History of polyps

Diarrhea Weight loss Nausea Vomiting Abdominal pain Constipation Heartburn/reflux

Difficulty swallowing Crohn's disease Ulcerative colitis Rectal bleeding Barrett's esophagitis

Other: _____

Medications: (Include prescriptions, over-the-counter medications, vitamins/supplements, minerals, herbs)

If additional space is needed, please attach a separate sheet. ☐ Separate sheet attached

Medication Name	Dosage	How Often Taken

Use of anti-inflammatory products / blood thinners: ☐ aspirin/Ecotrin _____ (mg) daily/wkly/as needed

☐ ibuprofen/Advil/Motrin _____ (mg) daily/wkly/as needed ☐ naproxen/Aleve _____ (mg) daily/wkly/as needed

☐ Coumadin/Plavix _____ (mg) daily/wkly/as needed ☐ Other: _____

Allergies/Reactions: ☐ Sedatives/Anesthetics - name/type of reaction: _____

☐ Latex - type of reaction: _____ ☐ Adhesives/tape/bandages

☐ Medications - name/type of reaction: _____

Personal Medical History: (circle all that apply: note 'past' or 'present')

	Past	Present
Neurological illness/stroke/seizures		
Eye/ear/nose/throat/thyroid disease		
Anxiety/depression/psychiatric disorder		
Chronic cough/shortness of breath		
Lung disease (Asthma/COPD)		
Sleep apnea/CPAP use		
GERD/Barrett's esophagitis		
Heartburn/reflux/nausea/vomiting		
Difficult/painful swallowing		
High blood pressure/heart valve disease		
Angina/heart attack/cardiac stent		
Irregular heartbeat/pacemaker/defibrillator		
Anemia/easy bruising or bleeding		
Jaundice/liver disease/gallbladder disease		
Bladder/kidney stones or disease		
Unexplained wt. loss or gain/eating disorder		
Abdominal pain/diarrhea/constipation/IBS		
Crohn's disease/ulcerative colitis		
Black/bloody stools		
Polyps (stomach or colon)		
Arthritis/fibromyalgia/gout		
Skin disease		
Diabetes		
Have you ever had a blood transfusion?	Yes - yrs	No
Antibiotics required prior to dental work?	Yes	No

Cancer* - type: _____

Surgical History: (List type and dates)

_____

Social History:

Alcohol/Drug use (how much/when quit)

_____ N/A

Tattoos/Piercings (location(s), yr placed)

_____

_____

Smoking (how much & when quit) N/A

_____

Occupation _____

Marital Status _____

Dietary Habits:

milk amount _____ daily/weekly

soda/pop amount _____ daily/weekly

coffee/tea amount _____ daily/weekly

gum chewing frequency _____ daily/weekly

(*Please complete reverse side of form)

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Family History Questionnaire

Patient Name: _____ **Physician:** _____

Date of Birth: _____ **Date Completed:** _____

Please complete the following to the best of your knowledge. If you have a family history of any of the conditions listed below, please fill in the relevant information. An example is shown in the first row.

Disease	Y/N	Relationship	Age
Ex: Colon cancer	***Y***	***Maternal Aunt***	***58***
Crohn's Disease			
Ulcerative colitis			
Barrett's esophagitis			
Celiac disease			
Hemochromatosis			
Colon polyps			
Colon cancer			
Esophageal cancer			
Stomach cancer			
Pancreatic cancer			
Liver cancer			
Small bowel cancer			
Uterine cancer			
Ovarian cancer			
Kidney/bladder cancer			
Thyroid cancer			
Brain cancer			
Skin cancer			
Breast cancer			
Prostate cancer			

Patient signature _____ Date _____

For office use only:

Physician Signature _____ Date _____

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Last Name _____ First Name _____ MI _____

Home Address _____

Home Phone _____ Date of Birth _____ Age _____

Cell Phone _____ Male / Female SS# _____

Work Phone _____ Employer _____ Occupation _____

Preferred Language _____ Race _____ Ethnicity _____

Email Address _____

How did you hear about GGR? _____

PRIMARY INSURANCE *(please bring insurance cards to ALL appointments)*

Insurance Company Name & Phone # _____

Insurance Company Billing Address _____

Insurance ID # _____ Effective Date _____

Name of Policy Holder _____ Relationship _____ Date of Birth _____

SECONDARY INSURANCE

Insurance Company Name & Phone # _____

Insurance Company Billing Address _____

Insurance ID # _____ Effective Date _____

Name of Policy Holder _____ Relationship _____ Date of Birth _____

I hereby authorize payment of medical benefits billed from my insurance to **Gastroenterology Group of Rochester, LLP.**
I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance.
I also accept responsibility for fees that exceed the payment made by my insurance. If a referral and/or precertification number are not provided at the time service is rendered, I will be responsible for the total amount due for services rendered.
I agree to pay all copayments, coinsurance and deductibles prior to service being rendered.

Print Name _____ Date _____

Signature of Patient or Guardian _____