Hilton Head Gastroenterology - Patient Registration

Date: _____

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)	ADDRESS		
CITY, STATE	ZIP	HOME PHONE	CELL PHONE
PATIENT DATE OF BIRTH	PATIENT SSN	SEX ❑ Male ❑ Female	MARITAL STATUS ❑ Single ❑ Married ❑ Other_____
OCCUPATION / EMPLOYER NAME	PATIENT EMPLOYER ADDRESS (STREET ADDRESS - CITY - STATE - ZIP)	EMPLOYER PHONE	

INSURED/RESPONSIBLE PARTY INFORMATION RELATION TO PATIENT: ❑spouse ❑parent ❑guardian

NAME (FIRST -- LAST -- MIDDLE INITIAL)	ADDRESS (if different from patient)			
HOME PHONE	WORK PHONE	SSN	BIRTH DATE	EMPLOYER

INSURANCE INFORMATION

PRIMARY INSURANCE NAME	ADDRESS (STREET - CITY - STATE - ZIP)	PHONE
GROUP NUMBER / ID NUMBER	EMPLOYER	EMPLOYER PHONE
SECONDARY INSURANCE NAME	ADDRESS (STREET - CITY - STATE - ZIP)	PHONE
GROUP NUMBER / ID NUMBER	EMPLOYER	EMPLOYER PHONE

OTHER DOCTORS YOU SEE:	YOUR EMAIL:	
EMERGENCY CONTACT	RELATIONSHIP	PHONE NUMBER

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

SIGNATURE (Patient or, if minor Signature of parent or guardian)	DATE

Authorization to release health information to:

Name(s)	ADDRESS		
CITY, STATE	ZIP	HOME PHONE	DAYTIME PHONE
DATES OF SERVICE FROM: TO:	AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED) ❑ NEVER DATE:		

RELEASE OF INFORMATION

I understand that:

- once "this facility" discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.
- I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524).
- My records are protected and cannot be disclosed without written permission
- This Authorization will remain in effect for one year or I provide a written notice of revocation to the Medical Record Department.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE	EMAIL

Hilton Head Gastroenterology – New Patient

HEALTH HISTORY

DATE:_____

Name (Last, First, MI) ☐ M ☐ F	**DOB:**	**Age:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Other doctors you see:	**Height:**	**Weight:**

REASON FOR YOUR VISIT?

Medical History and Previous Surgeries		
Year:	Medical Problem or Surgery:	Hospital if any:

Have you ever had a blood transfusion?	☐ Yes	☐ No

List your prescribed drugs and over-the-counter drugs, such as vitamins, supplements and inhalers:		
Name the Drug?	Strength?	How often do you take the medicine?

Allergies to medications	
Name the Drug / Problems:	

Hilton Head Gastroenterology – New Patient

NAME:	DATE:

HEALTH HABITS AND PERSONAL SAFETY						
Occupation:	**Exercise:**					
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	How many drinks per week?					
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Siblings, Children or Grandparents**		
Mother					

DIGESTIVE DISEASE HISTORY

Family history of colon cancer or colon polyps?	☐ Yes	☐ No
Who was it that had colon cancer or polyps?		
Date and location of last colonoscopy?		
Have you ever had an upper endoscopy?	☐ Yes	☐ No
Date and location of last upper endoscopy?		

REVIEW OF SYSTEMS / OTHER PROBLEMS

Check if you have any symptoms in the following areas to a significant degree and briefly explain.

☐ Abdominal Pain	☐ Chest Pain	☐ Recent changes in:
☐ Difficulty Swallowing	☐ Heartburn	☐ Weight
☐ Nausea Vomiting	☐ Vomiting Blood	☐ Energy level
☐ Bloating	☐ Diarrhea	☐ Ability to sleep
☐ Belching	☐ Change in bowel habits	☐ Other pain/discomfort:
☐ Constipation	☐ Rectal Bleeding	