Hilton Head Gastroenterology - Patient Registration Date: _____

	PLEASE PRINT AND COMPLETE ALL ENTRIES										
PATIENT NAME (LAST FIRST MIDDLE INITIAL) ADDRESS											
•		•									
CITY, STATE			ZIP	HOME PH	ONE	CELL PHONE					
,											
PATIENT DATE OF BIRTH PATIENT SSN			SEX		MARITAL ST						
			☐ Male	□ Female	□ Single □	Married 🗆 Other					
OCCUPATION / EMPLOYER NAME PATIENT EMPLOY			YER ADDRES	SS (STREET ADD	DRESS - CITY - STATE	ATE - ZIP) EMPLOYER PHONE					
THISLIPED (PESS)	NCIDLE DARTY	NEODMATION									
INSURED/RESPONSIBLE PARTY INFORMATION				RELATION TO PATIENT: □spouse □parent □guardian							
NAME (FIRST LAST I	MIDDLE INITIAL)	AD	DDRESS (if d	DRESS (if different from patient)							
HOME PHONE	WORK PHON	IE S	SN		BIRTH DATE	EMPLOYER					
						<u> </u>					
				INFORMATION							
PRIMARY INSURANCE N	AME	ADDRESS (STREET - C	ITY - STATE -	ZIP)	PHONE					
GROUP NUMBER	ID NUMBER	EM	IPLOYER			EMPLOYER PHONE					
SECONDARY INSURANCE	NAME	ADDRESS (STREET - C	ITY - STATE -	ZIP)	PHONE					
		(,						
	T										
GROUP NUMBER	ID NUMBER	EM	IPLOYER			EMPLOYER PHONE					
				,							
OTHER DOCTORS YOU SI	EE:				YOUR EMAIL:						
EMERGENCY CONTACT					DEL ATTONICUED	DUONE NUMBER					
EMERGENCY CONTACT					RELATIONSHIP	PHONE NUMBER					
ACCIONIMENT AND	DELEACE The	ale a that are	•	. l Ci l	and the said of the said	the state of the second st					
	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											
•	vered services.	I also authorize t	he physicia		ny information req	uired in the processing of this					
claim and all future cla	vered services. ims. If my acco	I also authorize t unt is sent to a c	the physician and collection are	gency, I agree	ny information req	uired in the processing of this					
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Hilton Head Gastroenterology - New Patient

HEALTH HISTORY

HEAL	TH HIST	ORY		DATE:								
Name (Last, First, N	MI)			□М	□ F	DOB):	Age:				
Marital status:	☐ Single	□ Partnered	□ Married	☐ Separated	□ Div	orce/	ed □ Wido	wed				
Other docto	ors you see:						Height:	W	/eigh	t:		
REASON F	OR YOUR VISI	Т?										
Medical His	story and Previou	s Surgeries										
Year:	Medical Problem o	or Surgery:				Hosp	ital if any:					
Have you e	ver had a blood t	cransfusion?								Yes		No
List your pr	rescribed drugs a	nd over-the-count	ter druas, such	n as vitamins, supp	lements	and	inhalers:					
Name the Dr			Strength				How often	n do you t	ake tl	he me	edicin	e?
Allergies to	medications		<u> </u>									
Name the Dr	rug / Problems:											
1			I									

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?								1		1		
Tobacco	Do you use to									Yes		No	
	□ Cigarettes	– pks./day	I	pe - #/day	pe - #/day								
		☐ Or year quit	Or year quit										
Drugs	Do you curren	tly use recr	eational or street d	rugs?						Yes		No	
FAMILY HEALTH HISTORY													
AGE SIGNIFICANT HEALTH PROBLEMS AGE SIGNIFICANT HEALTH PROBLEMS												MC	
	AGE	ICANT HEALTH PRO			AGE	SIGNIF	TCANT F	IEALI	ПРКС	JDLEI			
Father				Siblings, Children or									
Mother					Grandparents								
			DIGES	STIVE DIS	SEASE HISTOR	Y							
Family history of colon cancer or colon polyps?								Yes		No			
Who was it that had colon cancer or polyps?													
Date and location	n of last colonos	copy?											
Have you ever had an upper endoscopy?									Yes		No		
Date and location of last upper endoscopy?													
			DEVIEW OF	CVCTEM	C / OTHER BRO	DI FMC							
			KEVIEW OF	SYSTEM	S / OTHER PRO	BLEMS							
Check if you have any symptoms in the following areas to a significant degree and briefly explain.													
□ Abdominal Pain □ Chest Pain □ Recent changes in:							es in:						
□ Difficulty Sw	Difficulty Swallowing					□ Weight							
□ Nausea Vomiting □ Vomiting Blood							☐ Energy level						
□ Bloating □ Diarrhea							☐ Ability to sleep						
□ Belching □ Change in bowel habits					abits		Other pain/dis	scomfort	:				
□ Constipation	□ Constipation □ Rectal Bleeding												