



PATIENT DATA
FORM MUST BE COMPLETED IN FULL

Today's Date \_\_\_\_\_

Name \_\_\_\_\_

Mailing Address \_\_\_\_\_
Street City State Zip

Date of birth: \_\_\_\_\_ Patient's SSN \_\_\_\_\_ Gender [ ] Male [ ] Female

Phone Numbers: Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Preferred contact number? [ ] Home [ ] Cell [ ] Work May we leave messages on your voicemail? [ ] Yes [ ] No

Email Address \_\_\_\_\_

Preferred language: [ ] English [ ] Spanish [ ] Other \_\_\_\_\_

Race: [ ] American indian/Alaskan native [ ] Asian [ ] Black/African American
[ ] Native Hawaiian/Other Pacific Islander [ ] White [ ] Other race [ ] Unknown [ ] Declined

Ethnicity: [ ] Hispanic or Latino [ ] Non-Hispanic or Latino [ ] Declined

Emergency contact: \_\_\_\_\_
Name Relationship Phone

INSURANCE/GUARANTOR INFORMATION

Policy Holder's Name \_\_\_\_\_ Policy Holder Date of Birth \_\_\_\_\_

Name of Primary Insurance \_\_\_\_\_ Name of Secondary Insurance \_\_\_\_\_

Patient's Employer \_\_\_\_\_

Referring Dr \_\_\_\_\_ Primary Care Dr \_\_\_\_\_

Preferred Pharmacy \_\_\_\_\_
Name City Phone

Have you had a colonoscopy in the past 10 years? [ ] Yes [ ] No

Have you had an EGD (exam of esophagus and stomach) in the past 10 years? [ ] Yes [ ] No

If yes: \_\_\_\_\_ Physicians name \_\_\_\_\_
City/State



GUNTERSVILLE OFFICE PHONE: 256-571-8810  
FAX: 256-571-8880

BOAZ OFFICE PHONE: 256-840-4840  
FAX: 256-840-4844

**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES**

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Medical Specialists of North Alabama's Notice of Privacy Practices. By signing below I am only giving acknowledgement that I have received or have had the opportunity to receive the Notice of Privacy Practices.

\_\_\_\_\_  
Patient Name (Printed)

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**RELEASE OF INFORMATION AUTHORIZATION:**

Due to federal privacy guidelines (HIPPA), Medical Specialists of North Alabama is not allowed to divulge information to anyone other than the patient (or guardian of the patient) unless explicit written authorization is given to discuss personal medical information with someone other than you.

I, \_\_\_\_\_, give Medical Specialists of North Alabama permission to release / discuss personal medical information to include the pickup of prescriptions and / or financial information to:

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**GUARANTEE OF ACCOUNT: MUST BE 19 YEARS OF AGE TO SIGN**

I, the undersigned, directly assign to Medical Specialists of North Alabama all surgical and / or medical benefits, if any, otherwise payable to me for services rendered.

In consideration of services rendered or to be rendered, the undersigned agrees to pay all costs of collection and / or reasonable attorney fees, should the account be turned over to enforce collections of said charges.

I hereby authorize Medical Specialists of North Alabama to release any information necessary to secure payment of benefits to my account.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

We are grateful you have chosen our practice to provide you with gastroenterology care. Please carefully read over the following policies, initial, sign and date.

*Please Initial*

<p><b><u>Cell phone use</u></b> As a courtesy to others, we request you turn off your cell phone while in clinical areas.</p>	
<p><b><u>Fees</u></b> Patients are expected to pay all co-pays at the time of your visit.</p>	
<p><b><u>Nurse calls &amp; questions</u></b> The receptionist will take your name, number and reason for your call. Calls will be returned by the end of the next business day.</p>	
<p><b><u>Appointment Times</u></b> Please arrive early for your scheduled appointment. If you are late you will be asked to reschedule.</p>	
<p><b><u>Cancellations</u></b> The office requests 24 hour notice prior to your scheduled appointment time. If you cancel or fail to come for 3 appointments, we reserve the right to NOT reschedule any future appointments.</p>	
<p><b><u>No Show/Rescheduling</u></b> Patient's that NO SHOW for 3 appointments or reschedule 3 consecutive appointments are subject to dismissal from our practice for non-compliance.</p>	
<p><b><u>Treatment adherence</u></b> Taking your medicine as prescribed is vital for controlling chronic conditions and overall long-term health and well-being. Certain chronic diseases and medications or infusions require close laboratory monitoring. Failure to have required testing and/or scheduled infusions is considered non-compliance and is subject to dismissal from the practice.</p>	
<p><b><u>Form completion</u></b> There is a 5 business day turnaround time for FMLA or other forms needing completion. There is a \$20 charge per form.</p>	

These policies enable us to better serve you, our patient. Please sign below that you have read and agree to the above guidelines.

\_\_\_\_\_  
Patient Signature

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date of Birth

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Today's Date

Today's date \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_

Other physicians involved in your healthcare \_\_\_\_\_

**DESCRIBE the reason(s) for your visit** \_\_\_\_\_

1. Have you travelled outside the United States in the past 6 months?  Yes  No

**2. PATIENT MEDICAL HISTORY**

Check all that apply.

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Cirrhosis                | <input type="checkbox"/> Stomach/Intestinal Ulcers      | <input type="checkbox"/> HIV/AIDS                   |
| <input type="checkbox"/> Colon Cancer             | <input type="checkbox"/> Ulcerative Colitis             | <input type="checkbox"/> Hyperlipidemia/Cholesterol |
| <input type="checkbox"/> Colon Polyps             | <input type="checkbox"/> Anemia                         | <input type="checkbox"/> Hypertension/HBP           |
| <input type="checkbox"/> Constipation             | <input type="checkbox"/> Anxiety/Depression             | <input type="checkbox"/> Hypothyroidism             |
| <input type="checkbox"/> Crohn's Disease          | <input type="checkbox"/> Arthritis                      | <input type="checkbox"/> Kidney Disease             |
| <input type="checkbox"/> Diverticulosis           | <input type="checkbox"/> Asthma                         | <input type="checkbox"/> Migraines                  |
| <input type="checkbox"/> GERD/Reflux              | <input type="checkbox"/> Cancer: Type _____             | <input type="checkbox"/> Sleep Apnea                |
| <input type="checkbox"/> Hepatitis B              | <input type="checkbox"/> Congestive Heart Failure (CHF) | <input type="checkbox"/> Seizures                   |
| <input type="checkbox"/> Hepatitis C (HCV)        | <input type="checkbox"/> COPD/Emphysema                 | <input type="checkbox"/> Stroke (CVA)               |
| <input type="checkbox"/> Hiatal Hernia            | <input type="checkbox"/> Coronary Artery Disease (CAD)  | <input type="checkbox"/> TIA (Mini-stroke)          |
| <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Diabetes                       | <input type="checkbox"/> Other _____                |
| <input type="checkbox"/> Liver disease            | <input type="checkbox"/> Heart Attack                   | _____   |
| <input type="checkbox"/> Pancreatitis             |   |   |

**3. VACCINES**

Have you ever had a Pneumococcal (pneumonia) Vaccine?  Yes  No

Have you ever had the following vaccines?  Influenza (Flu)  Hepatitis A  Hepatitis B

**4. SURGICAL HISTORY**

Check all that apply.

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Colon Surgery           | <input type="checkbox"/> CABG/Heart surgery     | <input type="checkbox"/> Prostate Surgery          |
| <input type="checkbox"/> Hemorrhoid Surgery      | <input type="checkbox"/> Defibrillator          | <input type="checkbox"/> Spinal surgery            |
| <input type="checkbox"/> Gallbladder Surgery     | <input type="checkbox"/> Heart Stents           | <input type="checkbox"/> Thyroidectomy             |
| <input type="checkbox"/> Gastric Surgery         | <input type="checkbox"/> Hernia Surgery         | <input type="checkbox"/> Transplant surgery        |
| <input type="checkbox"/> Liver Surgery           | <input type="checkbox"/> Hysterectomy           | <input type="checkbox"/> Tubal Ligation            |
| <input type="checkbox"/> Hiatal Hernia Surgery   | <input type="checkbox"/> (Abdominal or Vaginal) | <input type="checkbox"/> Valve Replacement surgery |
| <input type="checkbox"/> Small Intestine Surgery | <input type="checkbox"/> Joint replacement      | <input type="checkbox"/> Vascular Stents,          |
| <input type="checkbox"/> Appendectomy            | <input type="checkbox"/> Laparoscopy            | Location _____                                     |
| <input type="checkbox"/> Brain Surgery           | <input type="checkbox"/> Obesity Surgery,       | <input type="checkbox"/> Other _____               |
| <input type="checkbox"/> Breast Surgery          | Type _____                                      | _____  |
| <input type="checkbox"/> C-Section               | <input type="checkbox"/> Pacemaker              |  |

Name \_\_\_\_\_ DOB \_\_\_\_\_

**5. MEDICATIONS** List current medications (including Herbal and Over the Counter)

Drug	Strength	Dose

Drug	Strength	Dose

Are you currently taking any blood thinners?  Brilinta  Coumadin  Plavix  Warfarin  Xarelto  
 Effient  Other \_\_\_\_\_

Are you currently taking any of the following aspirin/NSAIDs?  Advil  Aleve  Aspirin  BC Powder  
 Excedrin  Goody powder  Ibuprofen  
 Naprosyn  Fish Oil

**6. ALLERGIES**

List any medication allergies.  No known medication allergies

\_\_\_\_\_

\_\_\_\_\_

**7. FAMILY HISTORY** Check all that apply

	Mother	Father	Brother	Sister	Grandmother	Grandfather
Barrett's Esophagus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon Polyps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>CANCERS</b>						
Breast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Esophagus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pancreas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**8. SOCIAL HISTORY** Provide detail regarding current and/or past use of the following:

Alcohol (beer, wine, liquor)  Yes  No Usage \_\_\_\_\_

I.V. or Recreational Drugs  Yes  No Usage \_\_\_\_\_

Tobacco (cigarettes, cigars, chewing tobacco)  Yes  No Usage \_\_\_\_\_

Caffeine Use (coffee, tea, soda, energy drinks)  Yes  No Usage \_\_\_\_\_

Date of last menstrual period \_\_\_\_\_

**Please Print**

Patient Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Authorization to Release Protected Health Information**

I understand that:

- ✓ I may refuse to sign this authorization and that it is strictly voluntary.
- ✓ My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this a uthorization.
- ✓ I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
- ✓ **Unless otherwise revoked, this authorization will expire on the following date, event or condition:**  
\_\_\_\_\_. *If I do not specify expiration this authorization will not expire.*
- ✓ I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.
- ✓ I understand that I may see and obtain a copy of the information described in this form, for a reasonable copy fee, if I ask for it.
- ✓ I can request a copy of this form after I sign and date it.

If applicable, I also give permission for the following to be disclosed (please initial):

- \_\_\_\_\_ acquired immunodeficiency syndrome (AIDS) or infection with human immunodeficiency virus (HIV)
- \_\_\_\_\_ behavioral health services/psychiatric care
- \_\_\_\_\_ treatment for alcohol and/or drug abuse

**Signature\*:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*\*For non-emancipated minors under the age of 19 years, a parent or guardian must sign release form. If patient is unable to sign a copy of the legal documentation for patient's representative must be supplied with a copy of this form.*

• OFFICE USE ONLY •

**Release Information To Medical Specialists of North Alabama PLEASE FAX TO: 256-571-8880**

Released From: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Date Range: \_\_\_\_\_

- Office Notes   
  Radiology Reports   
  Labs   
  Operative Reports   
  Complete Medical Record  
 Complete Hospital Record   
  Pathology Reports   
  Other: \_\_\_\_\_

**Release Information From Medical Specialists of North Alabama To:**

Name / Facility: \_\_\_\_\_ Attention: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Fax #: \_\_\_\_\_

Purpose of Request:  Personal     Treatment     Legal     Insurance     Transfer     Other: \_\_\_\_\_