Carolina Digestive Disease

George A. Jenkins III, MD
Spencer J. Jenkins, MD
D. Tupper Iseman, MD

1520 Taylor Street • Suite 200 • Columbia SC 29201 • 803.509.5710 (p) • 803.509.5711 (f)

Social Security #: _____ Date: _____

Full Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Date of Birth: _____

Employer/School: _____ Occupation: _____

Employer Address: _____ Work Phone #: _____

Email: _____ Marital Status: ☐S ☐M ☐D ☐W Driver's License #: _____

Cell Phone #: _____ Emergency Contact: _____ Phone #: _____

Referred by: _____ Primary Care Physician: _____

## PRIMARY INSURANCE TO FILE

Policy #: _____ Group #: _____ Insured's Name: _____

Relationship to Patient: _____ Insured's SSN / ID#: _____

Insurance Co. Name: _____ Insurance Co. Phone #: _____

Insured's Date of Birth: _____

## SECONDARY INSURANCE TO FILE

Policy #: _____ Group #: _____ Insured's Name: _____

Relationship to Patient: _____ Insured's SSN / ID#: _____

Insurance Co. Name: _____ Insurance Co. Phone #: _____

Insured's Date of Birth: _____

May we leave messages containing medical information on your voice mail or answering machine?

☐ Yes ☐ No If yes, please authorize the phone number (shown above) we may use: ☐ Home ☐ Work ☐ Cell

I understand that payment is due at the time service is rendered. I hereby authorize the release of any medical information to: (1) an Insurance Company through which I claim benefits; and (2) any physician involved in my medical care. I realize this authorization allows Carolina Digestive Disease PA to release information to any of my insurers or physicians as requested by any such insurer or physician.

I hereby assign all medical and/or surgical benefits to which I am entitled including Medicare, Private Insurance Group Policy Benefits and other health plans to Carolina Digestive Disease PA. Carolina Digestive Disease PA does not extend credit. I hereby agree to pay all costs and reasonable attorney fees in the event this account is turned over to an attorney at law for collection.

Patient Signature: _____ Date: _____

Responsible Party Signature (if different): _____ Date: _____

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## PRACTICE POLICIES

Thank you for selecting our practice for your gastroenterology service. We are committed to patient satisfaction and quality care. The following policies have been implemented in order to give each patient the most efficient care.

1. Please bring an updated list of all current medications to each visit.

2. Refill requests must be called to our office from 9am – 4pm, Monday through Thursday and 9am – 1pm on Friday. Please refrain from calling after normal business hours for regular medication refills. Approval from the physician is required before our staff may call in your prescription. Allow ample time before running out of medications.

3. There will be a $25 fee for any missed office visit not canceled 24 hours prior to the appointment time. There will be a $100 fee for any missed endoscopic procedure not canceled 24 hours prior to the appointment time. AS MANPOWER AND FACILITY EXPENSES OCCUR IN PREPARATION FOR YOUR APPOINTMENT, YOU WILL BE PERSONALLY RESPONSIBLE FOR THESE CHARGES.

## CONSENT

You agree to permit your protected health information to be used and disclosed for purposes of treatment, payment and health care operations. For more details about these uses and disclosures, please see our Privacy Notice.

We reserve the right to change our privacy policies described in the Privacy Notice. You may call us to receive an updated Privacy Notice.

You have the right to request that we restrict how your protected health information is used or disclosed to carry out treatment, payment or health care operations. We are not required to agree with this request, but if we do, we are bound by it.

You have the right to revoke your consent in writing. A revocation, however, will not apply to the extent we have taken action in reliance upon the use or disclosure of your information.

_____ _____

Signature (Patient/Guardian) Date

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## ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of Carolina Digestive Disease PA's Privacy Notice, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice and request the following restriction(s) concerning the use of my personal medical information.

1. _____
   _____
2. _____
   _____
3. _____
   _____

☐ No restrictions are needed.

Further, I permit a copy of this authorization to be used in place of the original.

Signature: _____ Date: _____

If not signed by the patient, please indicate relationship to patient (e.g. Spouse).

Relationship: _____ Witness Signature: _____

## FOR INTERNAL USE ONLY

If patient or patient's representative elects to not sign this Acknowledgement of Receipt of Privacy Notice, document the date and time the notice was presented to patient and sign below.

Date Presented: _____ Time Presented: _____

By: _____ _____

Staff Name Staff Title

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Name: _____ Today's Date: _____

## Please place a check mark next to any of the following symptoms you are currently experiencing.

**General** ☐ Weight loss ☐ Weight gain ☐ Fever

**Psychological:** ☐ Anxiety ☐ Depression ☐ Hallucinations Psychiatric Hospitalization: _____

**Gastrointestinal:** ☐ Bloating/Excessive Gas ☐ Black Tarry Stool ☐ Change in bowel movements ☐ Frequent Constipation ☐ Frequent Diarrhea ☐ Heartburn/Reflux ☐ Nausea ☐ Vomiting ☐ Vomiting Blood ☐ Difficulty Swallowing ☐ Jaundice (yellowing of skin/eyes ☐ Rectal Bleeding ☐ Rectal Pain/Burning/Itching ☐ Loss of Appetite

**HEENT:** ☐ Eye Pain ☐ Eye Redness ☐ Sore Throat ☐ Mouth Ulcers ☐ Post Nasal Drip

**Respiratory:** ☐ Chronic Cough ☐ Difficulty breathing ☐ Asthma/Wheezing ☐ Snoring (causing you to wake up) ☐ Oxygen Use at Home; L/min _____

**Cardiovascular:** ☐ Chest pain ☐ Significant Swelling in the Legs ☐ Shortness of Breath (while lying flat) ☐ Arrhythmia

**Urinary:** ☐ Blood in Urine ☐ Dark/Tea-Colored Urine ☐ Burning with Urination

**Muscular:** ☐ Joint Swelling ☐ Joint Pain ☐ Chronic Back Pain

**Neurological:** ☐ Recent Change in Vision ☐ Frequent Headaches ☐ Dizziness ☐ Numbness/Tingling ☐ Weakness in: ☐ Generalized ☐ Focal (arm/leg)

**Skin:** ☐ Rash or Bruising

**Seasonal Allergies:** ☐ Hay Fever ☐ Hives/Angloedema

**Other:** _____

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Name: _____ Today's Date: _____

Marital Status: ☐Married ☐Widowed ☐Single ☐Divorced

Pharmacy, Phone Number, and Address: _____

**Personal Medical History:** *(check or check/describe all that apply)*

☐ History of Colon Polyps ☐ Cirrhosis/Hepatitis: _____ ☐ Sleep Apnea - CPAP: _____ ☐ High Blood Pressure
☐ Personal History of Cancer: _____
☐ Crohn's Disease ☐ HIV/AIDS ☐ Asthma ☐ Heart Attack ☐ Peripheral Vascular Disease ☐ Ulcerative Colitis ☐ Chronic Kidney Disease
☐ Seizures ☐ Cardiac Stents ☐ Vascular Stents ☐ Reflux Disease ☐ Migraines ☐ Fibromyalgia ☐ Cardiac By-Pass Surgery
☐ Insulin-Dependent Diabetic ☐ Non-Insulin-Dependent Diabetic ☐ Stomach Ulcers ☐ Thyroid Disease ☐ Schizophrenia ☐ Pacemaker
☐ Barrett's Esophagus ☐ Stroke ☐ Anxiety/Depression ☐ Defibrillator ☐ Glaucoma ☐ Pancreatitis ☐ COPD ☐ Bipolar
☐ Congestive Heart Failure ☐ High Cholesterol *If you have a condition(s) not listed above, please describe it here:*

_____

**Allergy to Medications/Dyes or Shellfish:** ☐ Yes ☐ No *(If yes, list medications and reactions)* _____

_____

**Family History:** ☐Colon Polyps, Relationship: _____ ☐Colon Cancer, Relationship: _____ ☐Liver Disease
☐Celiac Disease ☐Crohns ☐Colitis ☐Other: _____

**Do you use tobacco products?** ☐Yes ☐No ☐ Former User *If yes:* Type of Product(s) _____ Amount Daily: _____

**Do you use marijuana?** ☐Yes ☐No *If yes:* How often? _____ Other drugs? _____

**Do you drink alcohol?** ☐Yes ☐No *If yes:* How Much and How Often: _____

**Current Medications:** *(include prescriptions, vitamins, supplements, and other-the-counter medications)*
ATTACH LIST OR COMPLETE BELOW

| PLEASE INCLUDE DOSAGES, IF KNOWN. IF NEEDED, LIST ADDITIONAL MEDICATIONS ON THE BACK OF THIS FORM | | |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Do you take any blood thinners? *(circle all that apply):* ☐Aspirin 81mg ☐Aspirin 325 mg ☐Coumadin ☐Plavix
☐Xarelto ☐Pradaxa ☐Brilinta ☐Ticlopidine ☐Pletal ☐Eliquis ☐OTHER: _____

**Surgical History:** *(please list all surgeries, if known)* _____

**Have you even had an EGD/Upper Endoscopy?** ☐ Yes ☐ No *If yes, provide date, doctor, finding (if known)*

_____

**Have you even had a colonoscopy?** ☐ Yes ☐ No ☐ Yes ☐ No *If yes, provide date, doctor, finding (if known)*

_____