specialists in gastroenterology
powered by GI Alliance

Patient Information

Name: _____ Birth Gender: ☐Male ☐Female Gender Identity: ☐Male ☐Female
Last First Middle Initial Nickname

Address: _____
Street City State Zip Code

Social Security Number: _____ DOB: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Employer: _____ _____ Occupation: _____
Company Name Phone Number

Ethnicity: ☐Non Hispanic or Latino ☐Hispanic or Latino ☐Declined

Race: ☐White ☐Asian ☐Black/African American ☐Native Hawaiian/Pacific Islander ☐Declined ☐American Indian/Alaska Native ☐Other

Preferred Language: ☐English ☐Spanish Other: _____

Marital Status: _____ Spouse's Name: _____ Spouse's DOB: _____

Spouse's Social Security Number _____ Spouse's Phone: _____

Spouse's Employer: _____ _____ Spouse's Occupation: _____
Company Name Phone Number

In Case of Emergency Contact: _____ _____ _____
Name **Relation** **Phone Number**

Responsible Party (If Patient is Under 18)

Name: _____
Last First Middle Initial Nickname

Address: _____
Street City State Zip Code

Home Phone: _____ Cell Phone: _____ Email: _____

Employer: _____ _____ Occupation: _____ _____
Company Name Phone Number

Physician Information

Primary Care Physician: _____ Phone Number: _____

Referring Physician: _____ Phone Number: _____

Medical Insurance Information

Primary Insurance Company: _____

Policy Number: _____ Group Number: _____

Policy Holder: _____ Policy Holder DOB: _____ Relationship To Policy Holder: _____

Secondary Insurance Company: _____

Policy Number: _____ Group Number: _____

Policy Holder: _____ Policy Holder DOB: _____ Relationship To Policy Holder: _____

_____ _____ _____
Signature Date of Birth Date

_____ _____ _____
Legal Guardian Signature (If other than Patient) Legal Guardian (Print Name) Date

specialists in gastroenterology

powered by GI Alliance

Notice of Privacy Practices

Patient Health Information
Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We Use Your Patient Health Information
We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment, and Health Care Operations
Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.
Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.
Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses
We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures
We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:
Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
Research: We may use or disclose information for approved medical research.
Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
Health oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
Judicial and administrative proceedings: We may disclose information in response to an appropriate subpoena or court order.
Law enforcement purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.
Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
Serious threat to health or safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-elated injuries or illness.
In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights
You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.
Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions. Also, if you have paid for your health care treatment out-of-pocket and in full, and if you request that we limit disclosure of your information to a health plan for purposes of payment or health care operations, we will abide by your request.
Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments. *Inspect and Obtain Copies:* In most cases, you have the right to look at or get a copy of your health information in electronic or paper form. There may be a small charge for the copies.
Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.
Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person (s) listed below.

Daria Brueggeman -Administrator
314-997-0554

Release of Medical Information
I authorize Specialists in Gastroenterology use/or disclose certain medical and/or billing information to:

Name: _____

Relationship:_____

Restrictions on the Disclosure of Medical Information (ONLY choose one below)

___ You can leave a detailed message (including billing, test results, medical information)

___ You leave a message with no detailed. Information except a call back number and "Specialists in Gastroenterology" or "Advanced Endoscopy Center" identified.

___ You may not leave a message.

Signature:_____ Date:_____
Patient or Legal Guardian

Printed Name: _____ DOB: _____

SIG
specialists in gastroenterology
powered by GI Alliance

Problems List

Name: _____ Birth Date:_____ Date:_____

Medical Conditions:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

Surgeries and Dates:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

Medical History (Personal/Family)

	Patient's History	Family (Parent, Sibling, Child)
Colon Polyps:	_____	_____
Colon Cancer:	_____	_____
Colitis/Crohn's Disease	_____	_____
Irritable Bowel:	_____	_____
Stomach Ulcer:	_____	_____
Gallstones:	_____	_____
Pancreas Disease:	_____	_____
Diabetes	_____	_____
Breast Cancer:	_____	_____
Uterine Cancer:	_____	_____

SIG
specialists in gastroenterology
powered by GI Alliance

Patient Medication Information

Patient Name:_____ **Patient DOB:**_____

Primary Pharmacy:_____ **Pharmacy Phone: (____)**_____

Medication Allergies:

Name	Reaction
(example: Sulfa)	(rash)

Medications: (Please Print all Medications, Supplements and Over the Counter Medications)

Name	Dose/mg	How Many Times a Day do You Take This Medication?	Why do you take this Medication?
(example: Aleve)	(200mg)	(as needed)	(headaches)
(example: Coumadin)	(5mg)	(once daily)	(blood thinner)