LANE PHYSICIAN GROUP

EMPLOYEE VERIFIED:_____DATE_____

PATIENT INFORMATION SHEET

ALLERGIES_____
LAST NAME_____ BIRTHDAY _____
FIRST NAME_____ HOME PHONE_____
ADDRESS_____ WORK PHONE_____
CITY_____LA_____ZIP_____ CELL PHONE _____
EMPLOYER/SCHOOL(ATTENDING)_____ SOCIAL SEC. # _____
FULL TIME STUDENT? _____YES____ NO DRIVER'S LICENSE#_____
SPOUSE_____SPOUSE DOB_____
PATIENT E-MAIL ADDRESS_____
DOES PATIENT HAVE A LIVING WILL?_____ YES_____NO
RESPONSIBLE PARTY INFORMATION (Parent or Guardian)
LAST NAME_____ DRIVER'S LICENSE#_____
FIRST NAME_____ HOME PHONE_____
ADDRESS_____WORK PHONE_____
CITY_____LA_____ZIP_____BIRTHDAY_____
EMPLOYER/SCHOOL (ATTENDING)_____ SOCIAL SEC. # _____
FULL TIME STUDENT? _____YES____ NO

INSURANCE CARRIER
1). INSURANCE NAME_____ INSURED'S NAME_____
GROUP# _____ POLICY # _____
ADDRESS_____
PHONE#_____
INSURED'S DOB_____ INSURED'S SS#_____
PATIENT RELATIONSHIP TO INSURED_____(Self, Spouse, Child)
IF YOU HAVE MORE THAN ONE INSURANCE, PLEASE ALLOW THE RECEPTIONIST TO COPY ALL OF THE CARDS.
EMERGENCY NOTIFICATION
NAME_____ RELATIONSHIP_____
PHONE_____ CITY_____

PLEASE READ AND SIGN
I understand that all services are charged to the patient, and as the patient, I am responsible for all charges not paid by my insurance. I hereby authorize Lane Physician Group to obtain my medication history by means of electronic access which becomes part of my permanent record. I hereby indemnify the physician office and its agents from any and all responsibility relative to obtaining such information. I acknowledge and give consent for treatment. I authorize Lane Physician Group to release my medical and financial information to my insurance carriers as necessary to receive payment. I authorizes payment to be made to lane Physician Group. If I have no insurance, full payment is made it time of service. As of Nov. 1, 2017 our office will charge a fee of $35.00 for not showing up for your appointment. When a time slot is left open because a patient does not call and cancel their appointment there is not enough time to notify another patient that is in need of being seen.

Date_____ Signature_____

GI HISTORY QUESTIONNAIRE Today's Date_____

Full Name: _____ DOB:___/____/____ AGE:_____

Referring Doctor:_____ PCP:_____

Current Medications

Prescription Name (ex. Atenolol)	Dose/Strength (ex. 50mg)	Directions (ex. Twice daily)	Reason (ex. Blood pressure)

Over the Counter Medications

□ I do not take any other the counter medications

Over the Counter Meds (ex. Tylenol, vitamins)	Dose/Strength (ex. 25 mg)	Directions (ex. as needed)	Reason (ex. Headaches)

Allergies

□ **NO KNOWN ALLERGIES**

Medication/Food Allergies			Type of Reactions(ex. Rash, stomach upset)
Penicillin?	□ NO	□YES	
Latex?	□ NO	□YES	
Sulfa Drugs?	□ NO	□YES	
Anesthesia Medicines?	□ NO	□YES	

Social History

Occupation:_____ Hobbies:_____

Do you use tobacco: □ Never □Yes _____packs per day for ____ years □Quit, Approx. Date_____

Do you drink alcohol? □Never □Social Drinker □2 or less/day □3 or greater/day

Do you use recreational drugs? □No □Yes; type_____ □Occasionally □Weekly □Daily

History of alcohol abuse? □No □Yes _____years

History of drug abuse? □No □Yes _____years

Past Medical History

Please check the box if you have any of the following conditions. **□ No History**

□Anemia	□Anxiety	□Arthritis	□Asthma
□Atrial Fibrillation	□Autoimmune Disorder: Type?_____	□ Bleeding Disorder: Type?_____	□Taking Blood Thinners (Plavix, Warfarin, Aspirin, etc.)
□Blood Transfusion	□Cancer: Type?_____	□Chest Pain	□COPD
□Colitis: Type?_____	□Colon Polyps	□Congestive Heart Failure	□Constipation
□Crohn's Disease	□ Diabetes	□Defibrillator	□Diverticulitis
□Diverticulosis	□GERD/Heartburn	□Glaucoma	□Heart Attack
□Heart Disease	□Heart Murmur	□Hemorrhoids	□Hepatitis: □A □B □C
□Hernia: Type: _____	□Home Oxygen Use	□Hyperlipidemia	□Hypertension
□Irritable Bowel Syndrome	□Kidney Stones	□Kidney Disease	□Liver Disease, Type:_____
□Migraines	□Pacemaker	□Peptic Ulcer Disease	□Seizures
□Sleep Apnea: □ Using CPAP/BiPAP	□Stroke	□TIA (Mini-Stroke)	□Tuberculosis

Review of Systems

Please check the box if you have any of the following symptoms **□ No Symptoms**

Constitutional	□Weight Change □Fevers □Chills □Feeling Tired
Head	□Headache □Head Trauma
Eyes	□Blindness □Wearing Glasses
Ear/Nose/Throat	□Hearing Loss □Snoring □ Throat Pain □Hoarseness □Mouth Sores
Cardiovascular	□ Chest Pain □Fast Heart Rate □Palpitations
Lung	□Shortness of Breath □Cough □Coughing up Blood □Wheezing
Genitourinary	□Painful Urination □Blood in Urine □Pregnant?
Musculoskeletal	□Joint Pain □Joint Stiffness
Skin	□Infection
Gastrointestinal	□Change in Appetite □Belching □Gagging □Regurgitation □Feeling Full □Bloating □Vomiting up Blood □Difficulty Swallowing □Heartburn □Nausea □Gas □Diarrhea □Vomiting □Abdominal Pain □Jaundice □Constipation □Change in Bowel Frequency □Change in Bowel Habits □Bright Red Blood from the Rectum □Rectal Pain
Neurological	□Tremors □Weakness □Numbness and Tingling
Metabolic	□Excessive Sweating □Excessive Thirst □Intolerant to Cold □Intolerant to Heat
Blood	□Past Blood Transfusion □Taking Blood Thinners
Infectious	□Recent Foreign Travel □Hepatitis □HIV/AIDS □Sexually Transmitted Disease
Psychological	□Sleep Disturbance □Anxious □Depressed □PTSD □Sexual Abuse

Previous Surgeries **□ No Surgeries**

Types of Surgery	Approximate Date/Year

Previous Endoscopic Procedures **□ No Procedures**

Type of Procedure	Date	Where	Findings
□Colonoscopy			□Normal □Abnormal:_____
□Upper Endoscopy/EGD			□Normal □Abnormal:_____
□Flexible Sigmoidoscopy			□Normal □Abnormal:_____
□GI Related Studies (Barium swallow, etc.) Type_____			□Normal □Abnormal:_____

Family History

Family Member	GI Cancer	GI Disorder	Polyps	Other Cancer
Mother	□No □Yes ____age	□No □Yes ____age	□No □Yes ____age	□No □Yes ____age
Father	□No □Yes ____age	□No □Yes ____age	□No □Yes ____age	□No □Yes ____age
Sibling	□No □Yes ____age	□No □Yes ____age	□No □Yes ____age	□No □Yes ____age

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please Review it carefully.

We respect your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

The law protects the privacy of health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations.

Examples of Use and Disclosures of protected Health Information for Treatment, Payment, and Health Operations

For Treatment:

- Information obtained by a nurse, physician, or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.
- We may also provide information to others providing your care. This will help them stay informed about your care.

For Payment:

- We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, procedures performed, or recommended care.

For Health Care Operations:

- We use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may contact you to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.
- We may use and disclose your information to conduct or arrange for services, including:
    - Medical quality review by your health plan;
    - Accounting, legal, risk management, and insurance services;
    - Audit functions, including fraud and abuse detection and compliance programs.

Your Health Information Rights

The health and billing records we create and store are the property of the practice/health care facility. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this Notice;
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request. But we will comply with any request granted;
- Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information ("Notice");
- Request that you be allowed to see and get a copy of your protected health information. You may also make this request in writing. We have a form available for this type of request.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My Signature confirms that I have been informed of my rights to privacy regarding my protected health information under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly or indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my medical providers *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my medical provider has the right to the *Notice of Privacy Practices* and that I may contact this office to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclose to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Date: _____

Signature (Guardian if Minor): _____

For Office Use Only:
We were unable to obtain patient's written acknowledgment of our Notice of Privacy Practices due to the following reason

	The patient refused to sign
	Communication barriers
	Emergency situation
	Other:

Lane Gastroenterology

Care You Can Count On

CONSENT FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I have been presented with a copy of this provider's **Notice of Privacy Policies,** detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning my medical information:

_____

_____

_____

If you wish for other person(s) to have access to your health information, please list them here:

Name:_____ Date of Birth: _____

Name:_____ Date of Birth: _____

Name:_____ Date of Birth: _____

Name: _____ Date of Birth: _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____

Date of Birth: _____

Soc Sec #: _____

I authorize the practice to release the information or records specified to upon request in person or by mail to the address specified at the time of the request.

Provider Name: _____

Provider Address: _____

_____

Provider City: _____

Provider State: _____

Provider Zip: _____

RECORDS AUTHORIZED TO BE RELEASED

	Complete Chart
	Office Notes
	Lab Reports
	Radiological Images
	Consultation Notes or reports
	Other:

I understand that I can revoke this authorization at any time by writing to the health care provider but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

_____ _____

Patient or Representative signature Date

_____

Print name of Representative and Relationship to Patient