FRONTIER
GASTROENTEROLOGY & HEPATOLOGY

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Welcome to Frontier Gastroenterology and Hepatology!

Checklist of things to bring to your first visit:

- Completed New Patient Form (this form)
- Photo ID
- Insurance cards
- Insurance co-pay
- All relevant testing from your physicians (labs, imaging, etc.)
- An accurate list of your medications

**PLEASE NOTE: It is also your responsibility to obtain the referral from your primary care physician if you are a member of an HMO. This needs to be received by our office prior to your visit with us.

Date of visit: _____ First name: _____ Last: _____ MI: ___ SSN: _____-____-_____

Birth date: _____ Age: ____ Gender: Male Female Race/Ethnicity: _____

Home address: _____ Apt#: _____ City: _____ State: ____ Zip: _____

Home phone: _____ Cell: _____ E-mail address: _____

Preferred method of contact: Home phone Cell phone call Cell phone text E-mail Online patient portal

Marital status: Single Married Divorced Widowed Separated Primary language: _____

Primary Care Provider: _____ PCP Phone: _____ PCP Fax: _____

Referred to our office by: _____ Referring provider Phone: _____

Pharmacy Name: _____ Pharmacy Phone: _____ Pharmacy address: _____

Employment status: Employed Self-employed Retired Disabled Unemployed Student Employer: _____

Occupation: _____ Employer address: _____ Work phone: _____

Emergency contact #1: _____ Phone: _____ Relationship: _____

Emergency contact #2: _____ Phone: _____ Relationship: _____

Primary insurance carrier: _____ Eligibility Phone number: _____

Policy holder ID: _____ Group ID: _____

Policy holder's name: _____ Date of birth: _____ Gender: Male Female

Policy holder's SSN: _____-____-_____ Relationship to patient: _____

Secondary insurance carrier: _____ Eligibility Phone number: _____

Policy holder ID: _____ Group ID: _____

Policy holder's name: _____ Date of birth: _____ Gender: Male Female

Policy holder's SSN: _____-____-_____ Relationship to patient: _____

Authorizations and Acknowledgements

Benefits: I request that payment of authorized benefits be made to Frontier Gastroenterology and Hepatology. I authorize any holder of my medical information to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine the benefits or the benefits payable for related services.

I hereby authorize the release of any confidential medical information, including information related to psychiatric care, drug and alcohol abuse, and HIV/AIDS, necessary to process insurance claims or any other medical information that is required for any healthcare related utilization review or quality assurance activities or to any healthcare professional requiring this information to treat me.

I hereby assign and authorize payment to Frontier Gastroenterology and Hepatology for all medical and/or surgical benefits, including major medical policies, to which I am entitled under any insurance claims or policies, any self-insurance program, or any other type of benefit plan. I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all medical fees and charges not directly reimbursed to Frontier Gastroenterology and Hepatology by any insurance policy, self-insurance program, or other benefit plan. This authorization shall remain in effect until revoked by me in writing. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I have a right to receive a copy of this authorization.

Initials: _____

Privacy: I acnknowledge that I received a copy of the "Notice of Privacy Practices (HIPAA)".

Initials: _____

Privacy: I authorize Frontier Gastroenterology and Hepatology to discuss my appointments, medical evaluation, treatment, and results to relatives or other persons as indicated:

Authorized person(s): _____

Advanced Directive: Do you have a Durable Power of Attorney or a Living Will? Yes No

Signature of patient/legal guardian/authorized person: _____

Relationship if other than patient: _____ Date: _____

Patient Medical History – Frontier Gastroenterology and Hepatology

Date of visit: _____ Patient name: _____ Age: _____

What is the reason for your visit today?:

_____

_____

_____

_____

Date of last colonoscopy: _____ Date of last EGD: _____

Symptoms you are currently having (circle all that apply):

General
Fevers
Chills
Sweats
Weight loss
Weight gain
Fatigue
Weakness (generalized)

Hematology/oncology
Bleeding disorders
Enlarged lymph nodes
Blood transfusion requirement

Urological
Blood in urine
Difficult or painful urination
Frequent urination
Loss of control of urination
Sexual dysfunction
Urinary tract infections

Allergy/immunology
Food allergy
Hives

Skin
Hair/nail changes
Itching
Rash

Cardiovascular
Chest pain
Palpitations
Poor circulation
Rapid heartbeat
Swelling of feet or legs

Neurologic / Psych
Confusion or disorientation
Fainting
Hallucinations
Memory loss
Phobias
Tremor
Weakness (localized)

Endocrine
Excessive thirst
Excessive urination
Intolerance to heat or cold

Gastrointestinal
Abdominal pain
Abdominal distension
Anorexia / bulimia
Black stools
Bloating
Bloody (red) stools
Constipation
Diarrhea
Difficulty swallowing
Gas
Heartburn
Loss of control of bowels
Nausea
Painful swallowing
Poor appetite
Rectal pain
Vomiting
Yellowing of eyes or skin

Pulmonary
Chronic cough
Coughing up blood
Shortness of breath
Wheezing

Ears, Nose, and Throat
Altered taste
Bleeding gums
Hoarseness
Post nasal drip
Voice changes

Musculoskeletal
Fibromyalgia
Joint pains
Muscle pain

Diseases you have or have had(circle all that apply):

Gastrointestinal	**Pulmonary**	**Hematology/Oncology**	**Skin**
Alcoholism	Asthma	Anemia	Dermatitis
Colon polyps	COPD	Cancer	Eczema
Colon cancer	Sleep apnea	Leukemia / lymphoma	
Colitis	Tuberculosis		**Urological**
Crohn's disease		**Cardiovascular**	Prostate problems
Diverticulitis	**Neuro/psych**	Chest pain	Kidney disease
Diverticulosis	Anxiety	Atrial fibrillation	Kidney stones
Gallstones	Depression	Abnormal heart rhythm	Venereal diseases
Hemorrhoids	Bipolar disorder	Congestive heart failure	
Hepatitis	Headaches/migraines	Heart attack	**Ears, Throat**
Hernia	Multiple sclerosis	High blood pressure	Hearing problems
Irritable bowel syndrome	Parkinson's disease	Rheumatic fever	Tonsillitis
Pancreatitis	Polio	Varicose veins	
Reflux	Seizures/tremors		**Endocrine**
Ulcers	Suicide attempt(s)		Diabetes
Vomiting blood	Strokes/TIA		High cholesterol or fats
	Schizophrenia		Thyroid dysfunction

Other conditions/illnesses not listed above:

_____

_____

Prior hospitalizations (provide name of hospital, reason for hospitalization, year of hospitalization, and outcome):

_____

_____

Social history:

Tobacco: How many packs daily? How many years? Did you quit? If so, which year? If not, intend to quit?

Alcohol: How many drinks daily and which kind? For how many years? Quit? If so, when? If not, intended?

Drugs: Ever used illicit drugs? If so, which kind and for how long? Quit? If so, when? If not, intended?

Medication Name	Dose	Frequency
Surgeries and Estimated Dates of surgeries:	**Family History (if Yes, include relation to you):**	**Allergies (Drug/Food/Environmental):**
	Colon cancer	
	Colon polyps	
	Other cancers	
	Crohn's Disease	
	Ulcerative colitis	
	Irritable bowel syndrome	
	Liver disease	
	Other	

Signature of patient/legal guardian: _____ Date: _____