Saratoga Schenectady Gastroenterology Associates, P.C.
Saratoga Schenectady Endoscopy Center, LLC
Phone: (518) 831-1500 Fax: (518) 377-1677

Medical History Form

Please provide us with a brief medical history: **Today's Date:**_____
Patient Name: _____ **Date of birth:** _____
Patient Acct #: _____

Primary Insurance Company: _____

What is the reason for your visit?_____

1. **From the list of symptoms below, please circle any that you have experienced recently.**

Nausea	Vomiting	Heartburn	Pain when swallowing
Black stools	Rectal pain	Constipation	Abdominal pain
Rectal bleeding	Loss of appetite	Diarrhea	Change in bowel habits
Weight loss	Difficulty swallowing (food gets stuck)		

2. **From the list of medical conditions below, please circle any you have experienced in the past.**

Stomach ulcers	Duodenal ulcers	Hepatitis	Liver Disease
Colitis	Gallstones	Colon polyps	Diverticulosis or Diverticulitis
High Blood Pressure	Diabetes	Stroke	Heart disease or Heart attacks
Seizures	Arthritis	Problems Sleeping	Sleep apnea COPD

Cancer If yes, what type of cancer?_____

3. **Please list any other medical problems:** _____

_____

4. **Do you have a pacemaker:** YES NO **Do you have an implanted Defibrillator** YES NO
5. **For women:**

Are you pregnant? Yes No Do you use contraceptives? Yes No

Last menstrual period (date): _____

6. **Please circle any surgeries you've had in the past.**

Appendectomy Gallbladder removed Cardiac Surgery Stent Placement Bowel Surgery

Hysterectomy Colonoscopy/Sigmoidoscopy If so when: _____

Please list all other surgeries you have had in the past:_____

_____

7. **Allergies to Medications:**_____

_____

Are you allergic to Eggs? YES NO If yes, what reaction:_____

Are you allergic to Soy? YES NO If yes, what reaction:_____

Are you allergic to Peanuts? YES NO If yes, what reaction:_____

Are you allergic to Nickel? YES NO If yes, what reaction:_____

PATIENT NAME: _____ **Date of Birth:** _____

Medical History Form Cont.

8. Please list all medications including over the counter medications that you are currently taking, including dosage and frequency:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

9. Are you prone to bleeding, or do you bleed easily? Yes No

10. Please circle any blood thinning Medications you take:

Aspirin Coumadin Plavix Xarelto Pradaxa Other

11. Would you accept a blood transfusion if necessary after a procedure? Yes No

12. Social History (Please indicate next to the items below how much you consume daily or weekly.)

Tobacco _____ Soda _____

Alcohol _____ Chocolate _____

Coffee/tea _____

Marital Status: Single Married Divorced Widowed Separated

Occupation: _____

13. Family History (Please circle any conditions your family members have.)

Colon Cancer: If yes, who? _____

Ulcerative Colitis: If yes, who? _____

Crohn's Disease: If yes, who? _____

Liver Disease: If yes, who? _____

Colon Polyps: If yes, who? _____

Mother Alive? Yes No If not, cause of death: _____

Father Alive? Yes No If not, cause of death: _____

14. From the list of general symptoms below, please circle any you have experienced recently.

Fevers	Rash	Headaches	Muscle aches
Double vision	Numbness/tingling	Cough	Anxiety/depression
Chest pain	Blurred vision	Trouble urinating	Loss of hearing
Blood in urine	Dizziness	Frequent urination	Shortness of breath
Intolerance to cold	Intolerance to heat	Leg swelling	painful or swollen glands
Excess sputum			

Physician's Signature: _____ **Date:** _____

Patient Registration Form

Account Number (Office use): _____

First Name: _____ Last Name: _____ M.I.: Birth Date:

Address: City, State: Zip:

Home #: Work #: Cell #: Email:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed Soc. Sec. #:

Sex: ☐ Male ☐ Female Employment Status: ☐ Employed ☐ Retired ☐ FT Student ☐ PT Student

Employer: Occupation:

Spouses Name: Spouses Birth Date:

We ask the following personal information as required under the "The American Recovery and Reinvestment act of 2009"

Primary Language: Ethnicity: ☐ Non-Hispanic or Latino ☐ Hispanic or Latino

Race: ☐ American Indian/Alaska native ☐ Asian ☐ African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ other

☐ Although I understand you are required to ask for above information, I am choosing not to provide it.

Please indicate who your referring and primary doctor's are below!!! Thank You!!!

Referring Doctor's Full Name: Referring Doctor's Phone #:

Primary Care Doctor's Full Name: Primary Care Doctor's Phone #:

Person to Contact in an Emergency: Emergency Contact Phone #:

INSURANCE INFORMATION

If you are covered by more than one insurance company, the insurance which is in your name is your primary insurance. The insurance which is in your spouse's name is your secondary insurance. If you are covered by only one insurance company, then that is your primary insurance.

PRIMARY INSURANCE COMPANY

Ins. Co. Name:

Ins. Co. Address:

City: State: Zip:

Policy ID #:

Group #: Co-pay Amount: $

Policy Holder's Name:

Policy Holder's Date of Birth:

Policy Holder's Relationship to Patient:

Effective Date of Policy:

SECONDARY INSURANCE COMPANY

Ins. Co. Name:

Ins. Co. Address:

City: State: Zip:

Policy ID #:

Group #: Co-pay Amount: $

Policy Holder's Name:

Policy Holder's Date of Birth:

Policy Holder's Relationship to Patient:

Effective Date of Policy:

If person responsible for bill is not the patient, please fill in this section!!!

Person Responsible for bill: Their Phone #:

Their address:

City: State: Zip:

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits to be paid directly to Saratoga Schenectady Gastroenterology Associates, P.C. and Saratoga Schenectady Endoscopy Center, LLC and acknowledge that I am financially responsible for any unpaid balance. I also authorize the release of any information acquired in the course of my examination or treatment to my insurance company.

Signature: _____ **Date:** _____

Permission to Share Your Protected Health Information

Saratoga Schenectady Gastroenterology Associates and Saratoga Schenectady Endoscopy Center health professionals, using their best judgment, may disclose health related information to a relative, close friend, or any other person you identify as being involved with your care. Please provide us with the names of those individuals who are involved in your care, with who we may share your protected health information to coordinate your care.
(In the event that you are a parent or legal guardian of a child treated by Saratoga Schenectady Gastroenterology Associates and/or Saratoga Schenectady Endoscopy Center, please provide us with the names of those individuals who are involved with the child's care, with who we may share protected health information to coordinate your child's care.)

☐ I do NOT want my information to be released to anyone other than myself.

_____ _____
Name of individual Relationship

_____ _____
Name of individual Relationship

I understand that if I wish to revoke permission to release protected health information to any or all of these individuals; it is my obligation to notify Saratoga Schenectady Gastroenterology Associates and/or Saratoga Schenectady Endoscopy Center of this decision in writing.

Name of Patient: _____DOB: _____

Signature: _____ Date:_____

If minor, Signature of Parent/Legal Guardian: _____

Patient Account #:_____

Acknowledgement of Receipt of Notice of Privacy Practices

I, **_____**, acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of Saratoga Schenectady Gastroenterology Associates, P.C. and Saratoga Schenectady Endoscopy Center, LLC, which describes the Practice's policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received, or maintained by the Practice.

Name of Patient: _____ DOB: _____

Patient Signature: _____Date: _____

Patient Account #: _____

FOR OFFICE USE ONLY IF NOTICE NOT PROVIDED TO PATIENT

The practice has made a good-faith effort to obtain an acknowledgement of above named patient's receipt of our Notice of Privacy Practices. In spite of these efforts, the Practice has been unable to obtain a signed acknowledgement of receipt for the following reasons (Circle all that apply)

Patient Unavailable Patient Physically Unable Patient Unwilling

In an effort to obtain the patients' acknowledgement, the practice has attempted to provide the patient with a Notice of Privacy Practices in the following manner (Circle all that apply):

Personally By Mail Phone Follow-up

☐ Other: _____

Staff Signature: _____ Date: _____