# GASTRO CENTER OF NEW SMYRNA BEACH

PATIENT INFORMATION SHEET TODAY'S DATE _____

Patient Name _____ Date of Birth:____/____/____ Age_____

Local Address _____ Social Security # _____/_____/_____

City _____ State____ Zip Code _____ Home Phone # (_____)_____-_____

Permanent Address _____ Cell Phone # (_____)_____-_____

Martial Status: Single_____ Married_____ Widowed_____ Divorced_____ _____Gender: M____ F____

Language _____ Ethnicity _____ Email _____

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OCCUPATION _____ WORK TELEPHONE (_____)_____-_____

PLACE OF EMPLOYMENT _____

WORK ADDRESS _____

SPOUSE'S NAME (SIGNIFICANT OTHER) _____ WORK TELEPHONE (_____)_____-_____

PERSON TO CONTACT IN EMERGENCY _____ PHONE (_____)_____-_____

PRIMARY PHYSICIAN _____ PHONE (_____)_____-_____

REFERRING PHYSICIAN (if different from Primary) _____

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DO YOU HAVE MEDICAL INSURANCE? _____ YES _____ NO

PRIMARY INSURANCE CARRIER _____

NAME OF INSURED _____ MEMBER ID# _____

GROUP# _____ BIRTHDATE OF INSURED _____/_____/_____

EMPLOYER _____

SS # OF INSURED_____/_____/_____ RELATION TO INSURED_____

SECONDARY INSURANCE CARRIER _____

NAME OF INSURED _____ MEMBER ID# _____

GROUP # _____BIRTHDATE OF INSURED _____/_____/_____

SS# OF INSURED _____/_____/_____ RELATION TO INSURED_____

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May we contact you at all phone numbers listed above? Yes_____ No_____

May we leave your personal health information on your answering machine/voicemail? Yes_____ No_____

Special instructions: _____

Please list anyone you give permission to speak with us on your behalf.

Name: _____ Relation: _____

Would you like to receive emails from Gastro Center of NSB? Yes_____ No_____

Patient Signature _____ Date:_____

# Gastro Center of New Smyrna Beach

GI REVIEW OF SYSTEMS

NAME: _____ DOB: _____

***Directions: Have you had any of the following in the last six months?***

| NO | YES | |
|---|---|---|
| ❑ | ❑ | chills |
| ❑ | ❑ | fever |
| ❑ | ❑ | lack of energy |
| ❑ | ❑ | weight loss |

| NO | YES | |
|---|---|---|
| ❑ | ❑ | chest pain |
| ❑ | ❑ | extremity swelling |
| ❑ | ❑ | palpitations |

| NO | YES | |
|---|---|---|
| ❑ | ❑ | painful urination |
| ❑ | ❑ | blood in urine |
| ❑ | ❑ | urinary frequency |
| ❑ | ❑ | urinary incontinence |
| ❑ | ❑ | urinary retention |

| NO | YES | |
|---|---|---|
| ❑ | ❑ | dizziness |
| ❑ | ❑ | headache |
| ❑ | ❑ | numbness |
| ❑ | ❑ | tremors |
| ❑ | ❑ | sensation of room spinning |

| NO | YES | |
|---|---|---|
| ❑ | ❑ | back pain |
| ❑ | ❑ | muscle pain |
| ❑ | ❑ | joint pain |

| NO | YES | |
|---|---|---|
| ❑ | ❑ | double vision |
| ❑ | ❑ | ear infections |
| ❑ | ❑ | eye pain |
| ❑ | ❑ | nasal congestion |
| ❑ | ❑ | sinus congestion |
| ❑ | ❑ | sore throat |

| NO | YES | |
|---|---|---|
| ❑ | ❑ | abdominal pain |
| ❑ | ❑ | change in bowel habits |
| ❑ | ❑ | constipation |
| ❑ | ❑ | diarrhea |
| ❑ | ❑ | difficulty swallowing |
| ❑ | ❑ | heartburn |
| ❑ | ❑ | vomit blood |
| ❑ | ❑ | blood in stool |
| ❑ | ❑ | loss of appetite |
| ❑ | ❑ | black stool |
| ❑ | ❑ | nausea |
| ❑ | ❑ | reflux |
| ❑ | ❑ | vomiting |

| NO | YES | |
|---|---|---|
| ❑ | ❑ | cold intolerance |
| ❑ | ❑ | excessive thirst |
| ❑ | ❑ | heat intolerance |
| ❑ | ❑ | breast enlargement |

| NO | YES | |
|---|---|---|
| ❑ | ❑ | anxiety |
| ❑ | ❑ | depression |
| ❑ | ❑ | increased stress |

| NO | YES | |
|---|---|---|
| ❑ | ❑ | easy bleeding |
| ❑ | ❑ | easy bruising |
| ❑ | ❑ | enlarged lymph glands |

| NO | YES | |
|---|---|---|
| ❑ | ❑ | short of breath |
| ❑ | ❑ | frequent cough |
| ❑ | ❑ | pain/breathing |
| ❑ | ❑ | wheezing |

| NO | YES | |
|---|---|---|
| ❑ | ❑ | asthma |
| ❑ | ❑ | chemical exposure work place |
| ❑ | ❑ | food allergies |
| ❑ | ❑ | altered/weakened immune system |
| ❑ | ❑ | seasonal allergies |

| NO | YES | |
|---|---|---|
| ❑ | ❑ | contact allergy |
| ❑ | ❑ | hives |
| ❑ | ❑ | itching |
| ❑ | ❑ | rash |

***Please bring a list of your current medications.***

# Gastro Clinic of New Smyrna Beach

PATIENT GENERATED MEDICAL HISTORY

Name: _____ DOB: _____ Date: _____

PCP: _____ Referring: _____ Copies to: _____

Pharmacy: _____ Pharmacy Phone #: _____

***Directions: Please circle any of the following you have personally had during your life?***

## YOUR PAST MEDICAL HISTORY:

Asthma/Emphysema/COPD

Blood Transfusion Date: _____

Cancer:

| | | |
|---|---|---|
| Breast | Liver | Pancreas |
| Colon | Lung | Prostate |
| Esophagus | Ovary | Stomach |
| Other _____ | | Uterus |

Congestive Heart Failure

Coronary Artery Disease

Crohn's Disease/Ulcerative Colitis

Diabetes Mellitus: Type 1 Type 2

GERD

High Blood Pressure

Irritable Bowel Syndrome

Liver Disease

Pancreatitis

Sleep Apnea

Ulcer Disease

Other_____

| ALLERGY | REACTION |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**LAST MENSTRUAL PERIOD** _____

Could you be pregnant? Y / N

## YOUR PAST SURGICAL HISTORY:

| | Date |
|---|---|
| Appendectomy | _____ |
| Artificial Heart Valve | _____ |
| Artificial Joint | _____ |
| Bowel Obstruction | _____ |
| Bowel (repair/resection) | _____ |
| CABG/Heart Bypass Vessels _____ | _____ |
| C-Section | _____ |
| Gallbladder Removal | _____ |
| Hysterectomy Total Partial | _____ |
| Neck Artery/Vascular Surgery | _____ |
| Pancreas Surgery | _____ |
| Surgery for Reflux/Hiatal Hernia | _____ |
| Surgery for Ulcers | _____ |
| Other _____ | _____ |

**MEDICAL PROBLEMS LIST/REASON FOR VISIT**

_____

_____

_____

_____

**YOUR SOCIAL HISTORY:**

Occupation _____ Working / Retired

Tobacco? Y/N Type: _____

Qty: ____ Former____ Yr. Stopped ____

Alcohol: Y/N Drinks/Day _____ Social _____

Former_____ Yr. Stopped _____

Recreational Drug Use: Y/N Type:_____

Marital Status: M S D W L

Children #: Y/N Boys: _____ Girls: _____

***Directions: Please circle any of the following that exists in your family.***

## YOUR FAMILY HISTORY:

| TYPE | RELATIONSHIP | Paternal/ Maternal | AGE |
|---|---|---|---|
| Cancer, Breast | _____ | P/M | _____ |
| Cancer, Colon | _____ | P/M | _____ |
| Cancer, Ovary | _____ | P/M | _____ |
| Cancer, Uterus | _____ | P/M | _____ |
| Cancer, _____ | _____ | P/M | _____ |
| Colon Polyps | _____ | P/M | _____ |
| Crohn's Disease | _____ | P/M | _____ |
| Gallstones | _____ | P/M | _____ |
| Liver Disease | _____ | P/M | _____ |
| Pancreatic Dis. | _____ | P/M | _____ |
| Ulcerative Colitis | _____ | P/M | _____ |
| Ulcers | _____ | P/M | _____ |

Mother: Alive Y/N If no, cause_____

Father: Alive Y/N If no, cause_____

Sister: Alive Y/N If no, cause_____

Brother: Alive Y/N If no, cause_____

Other Diseases That Run In The Family: _____

_____

_____

# FINANCIAL POLICY

**GASTRO CENTER OF NEW SMYRNA BEACH'S** staff will take the initiative insure timely submission of primary and secondary insurance claims for our patients. The patient, however, is responsible to provide all the necessary insurance information to ensure coverage for services rendered. Upon each visit, the patient will be asked to provide updated insurance details. Please bring your insurance card with you to your appointments and be sure to notify the staff if your insurance policy changes.

**OFFICE VISITS:** All payment is due and must be paid at the time of the visit to the physician. Each patient will be expected to pay before they exit the office- Please make sure that your plan covers your visit and Gastro Center of New Smyrna Beach accepts your insurance. Additionally, all co-payments, co-insurances, and/or deductibles are due at the time a service is rendered.

**REFERRALS AND AUTHORIZATIONS:** The patient is responsible for obtaining all referrals and authorizations prior to arriving for their scheduled appointment. The staff will assist in answering any questions that may arise from your insurance carrier, but the contact lies between you and your insurance company and therefore, you the patient, must obtain your authorization to be seen by the physician. Authorizations will not be obtained the day of your referral appointment, unless in the case of an emergency.

**ADMINISTRATIVE:** A $10.00 fee will be charged for forms needing to be filled out by our physicians and for patients requesting a medical letter from their physician.

**RETURNED CHECKS:** Payments made to Gastro Center of New Smyrna Beach that are not honored by the bank will incur a return check fee of $35.00. If failure to pay the check and fee within 15 days of receiving a return check notice from Gastro Center of New Smyrna Beach your account may be turned over to the State Attorney's office.

**APPOINTMENT NO-SHOWS/CANCELLATIONS**

A 48-hour notice must be given to cancel any procedure and a 24-hour notice must be given to cancel an office appointment. If the patient fails to provide the appropriate notice, the below policy may be enforced.

Any new or established patient who no-shows for a scheduled office appointment may be required to pay a $25.00 deposit before scheduling a new appointment. Any patient who no-shows for their scheduled procedure may be required to pay $100.00 deposit before scheduling a new procedure. Upon showing up for the next scheduled appointment the patient will be refunded the deposit. If the patient does not have insurance, the money will be applied towards that service. If the patient fails to show up for the next appointment or procedure we will keep the deposit provided to us.

Any requests for special payment arrangements must be made prior to your visit. You will need to contact the billing department to make special arrangements. They will not be made the time of your visit.

I certify that I have read and accept all terms set forth in this arrangement and I agree to pay GASTRO CENTER OF NEW SMYRNA BEACH for services rendered.

_____ _____

Patient Signature Date

# Gastro Center of New Smyrna Beach

**Antonio DeCarli, M.D.**

501 Live Oak Street, Suite B • New Smyrna Beach, FL 32168 • Phone 386-427-0309 • Fax 386-427-0394
www.gastrocenterofnewsmyrnabeach.com

| Request for Release of Medical Records | |
|---|---|
| **To:** | **From: Gastro Center of New Smyrna Beach Dr.:** |
| **Patient's name:**<br><br>**Patient's Date of Birth:** | **Today's Date:** |
| **Patient's Signature:** | |

By signing this release I give Gastro Center of New Smyrna Beach my permission to obtain my medical records to the below listed recipient. This release is effective for one year following the signed date of the release. I understand that this authorization extends to all or any part of my records which may include psychiatric, alcohol/drug, and/or AIDS information, any may include the result of HIV test or the fact an HIV test was performed. I expressly consent to the release of information as designated above. I understand this authorization extends to release information via U.S. mail, telephone, facsimile machine (fax), or email. I understand I have the right to revoke this authorization any time.

Please release the below requested documentation for continuity of a mutual patient's care. Thank you in advance for your assistance.

Records Requested:

_____

_____

_____

Thank you,

Name of person requesting: _____Date:_____

*This message is confidential, intended only for the named recipient(s) and may contain information that is privileged or exempt from disclosure under applicable law. If you are not the intended recipient(s), you are notified that dissemination, distribution or copying of this message is strictly prohibited. If you receive this message in error, or are not the named recipient(s), please notify the sender at the fax address or telephone number above and discard this fax. Thank You.*