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Endoscopy/Colonoscopy: Direct Booking

Dear patient:

Please complete the enclosed patient information forms and send them back. After you send the completed forms back, please allow 1 week for our office to review and call to schedule. If you don't hear from us in this time frame, please call our office. If you have had previous procedures, please document it on the form.

Please be sure to **check with your insurance company regarding coverage** for all appointments. It is helpful to inquire regarding coverage for both **screening and diagnostic colonoscopy procedures**. Although the procedure may be scheduled as a routine preventative screening, it could become diagnostic if any biopsy taken or diagnosis made at the time of the procedure. After scheduling your appointment, please **call your primary care physician's office to obtain a referral if applicable**.

If you need to cancel or reschedule an appointment, please call us at least 7 days in advance so that we may use that appointment for another patient.

Remember, endoscopic procedures require sedation making it unsafe to drive yourself home. You must plan on a driver being available to take you home approximately three to four hours after the scheduled exam time.

I hope you will find the enclosed information helpful. I wish you well as you go through the process, and look forward to seeing you for your examination. Please do not hesitate to call with any questions or concerns.

Sincerely,

*John G. Dowd, DO*

*Jennifer Naylor, MD*

*Andrea Fribush, MD*

*Julio Ayala, MD*

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

## Emerson Health Gastroenterology

Sex  Male  Female

Home Address \_\_\_\_\_

Phone Numbers Home: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Email address: \_\_\_\_\_

Marital Status  Married  Single  Widowed  Divorced  Other

Preferred Language  English  Spanish  Other \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

Pharmacy/address/town: \_\_\_\_\_

Mail order pharmacy: \_\_\_\_\_

May we discuss your condition with anyone? ( ) yes ( ) no

If yes, with whom? Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Other(s): \_\_\_\_\_

Who may we contact in case of an emergency? \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Phone number: \_\_\_\_\_

**\*\* IF YOUR INSURANCE REQUIRES REFERRALS YOU ARE RESPONSIBLE FOR OBTAINING THEM PRIOR TO YOUR APPOINTMENT. YOU WILL BE RESPONSIBLE FOR ANY CHARGES INCURRED FOR UNAUTHORIZED CARE. \*\***

Primary insurance company: \_\_\_\_\_

Subscriber's name/ relationship: (if not patient): \_\_\_\_\_ Date of birth: \_\_\_\_\_

Policy#: \_\_\_\_\_ Group#: \_\_\_\_\_

Secondary insurance company: \_\_\_\_\_

Subscriber's name/ relationship: (if not patient) \_\_\_\_\_ Date of birth: \_\_\_\_\_

Policy#: \_\_\_\_\_ Group#: \_\_\_\_\_

This information is given for the purpose of establishing an account and medical file with EMERSON HEALTH GASTROENTEROLOGY. It is understood that I shall be responsible for all charges incurred by me (or any minor child as noted above). I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize payment for any insurance claims be made directly to the physician.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Representative (minor/ unable to sign): \_\_\_\_\_ Date: \_\_\_\_\_

Relationship of patient representative to patient: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

## Emerson Health Gastroenterology

Reason(s) for your visit     Colonoscopy     Endoscopy     Colonoscopy & Endoscopy

Primary Care Physician \_\_\_\_\_

### 1) PAST MEDICAL HISTORY *(check all that apply)*

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> GERD/reflux              | <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Liver Disease         |
| <input type="checkbox"/> Colon Cancer       | <input type="checkbox"/> Hiatal Hernia            | <input type="checkbox"/> High Cholesterol     | <input type="checkbox"/> HIV/AIDS              |
| <input type="checkbox"/> Colon Polyps       | <input type="checkbox"/> Ulcers                   | <input type="checkbox"/> Irregular Heartbeat  | <input type="checkbox"/> Kidney Disease        |
| <input type="checkbox"/> Crohn's Disease    | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Heart Disease/Attack | <input type="checkbox"/> Asthma/COPD/Emphysema |
| <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Celiac Disease           | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Obesity               |
| <input type="checkbox"/> Diverticulitis     | <input type="checkbox"/> Pancreatitis             | <input type="checkbox"/> Stroke               | <input type="checkbox"/> Anxiety/Depression    |
| <input type="checkbox"/> Other: _____       |   |   |  |

Previous Gastroenterologist(s) \_\_\_\_\_

Last Upper Endoscopy: Date: \_\_\_\_\_ Location: \_\_\_\_\_

Last Colonoscopy: Date: \_\_\_\_\_ Location: \_\_\_\_\_

### 2) PAST SURGICAL HISTORY *(check all that apply and provide dates)*

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Appendectomy          | <input type="checkbox"/> Gallbladder Surgery | <input type="checkbox"/> Heart Surgery         |
| <input type="checkbox"/> Colon Surgery         | <input type="checkbox"/> Gastric Surgery     | <input type="checkbox"/> Hysterectomy          |
| <input type="checkbox"/> Caesarean (C section) | <input type="checkbox"/> Hernia Surgery      | <input type="checkbox"/> Nissen Fundoplication |
| <input type="checkbox"/> Stomach Surgery       |  |  |
| <input type="checkbox"/> Other: _____          |  |  |

### 3) MEDICATIONS

List current medications (including herbal) and dosage

_____	_____
_____	_____
_____	_____
_____	_____

If you are on a blood thinner, please state why: \_\_\_\_\_

### 4) ALLERGIES    No known medication allergies

List any medication allergies \_\_\_\_\_

### 5) FAMILY HISTORY

Does anyone in your family have a history of Colon Cancer, Colon Polyps, Barrett's Esophagus, Esophageal Cancer, or Stomach Cancer?

- YES     NO

If yes, who? \_\_\_\_\_