

TDDDC

Texas Digestive Disease Consultants

Today's date _____ Name of physician you are seeing today _____

Last name of patient _____ First _____ Middle initial _____

Street address _____

City _____ State _____ Zip _____

Home phone _____ Work phone _____

Mobile phone _____ E-mail address _____

Preferred method of contact (please circle one): home # work # cell # US mail

Date of birth _____ Age _____ Sex _____ Marital status _____

Social security number _____

Employed by _____ Occupation _____

Emergency contact _____ Relationship _____

Home phone _____ Work phone _____

Referred by _____ Primary care physician _____

Primary insurance _____ Insured name _____

DOB _____ SSN _____ Relationship _____

ID # _____ Group # _____ Insurance phone _____

Employer name _____

Secondary insurance _____ Insured name _____

DOB _____ SSN _____ Relationship _____

ID # _____ Group # _____ Insurance phone _____

Employer name _____

I have reviewed this office's notice of privacy practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Personal Representative

Date

I authorize the person(s) below to receive information regarding my medical care:

Name/Relationship

Name/Relationship

Agreement/Authorization Release

I authorize the release of any information including diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or health practitioners. I authorize my insurance company to pay directly to the doctor. If my insurance company does not pay, I understand that I will be responsible for payment. I agree to call my doctor's office if my test results have not been called to me within two weeks of completion of endoscopy/ scopes, blood tests, stool tests, biopsies/pathology and/or x-rays. I understand that my doctor may have a vested interest in the endoscopy center where my procedure may be performed.

Signature of Patient or Guardian

Date

Texas Digestive Disease Consultants

Patient Interview Form

First Name: _____ **Last Name:** _____
Account #: _____ **Date of Birth:** _____
Age: ____ **Gender:** _____ **Reason for Today 's visit:** _____
Current Other Physicians: _____

Race: White/Caucasian Black/African American Asian Hispanic/Latino
 American Indian or Alaska Native Native Hawaiian or Other Pacific Islander Mixed
 Other Unknown Patient declines to provide information
Ethnicity: Hispanic or Latino Not Hispanic or Latino Patient declines to provide information
Preferred Language: English Spanish Korean Other: _____

Contact Preference: Telephone call Other: _____

Allergies: Patient has no known allergies Patient has no known drug allergies
 Aspirin Codeine Demerol Fentanyl Flagyl
 Iodine IV Dye Levaquin/Cipro Morphine Penicillin
 Sulfa Versed Latex Eggs Shellfish
 Nuts Other: _____ Manifestations/Reactions: _____

Immunizations/When?: None Hepatitis B: _____ Hepatitis A: _____ Influenza: _____
 Pneumovax: _____ Tetanus: _____ Varicella/VZV: _____

Current Medications: None

| Name of Medication (Ex: Nexium) | Dosage (Ex: mg) | How often taken? (Ex: 1 pill per day) |
|----------------------------------|------------------|--|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Vitamins, Herbal and Dietary Supplements: None

Pharmacy Name/Address/Phone/Fax—Local and Mail Order: _____

Review of Systems:

Please indicate items you are CURRENTLY experiencing or "None" if no symptoms exist:

Gastrointestinal None

- Abdominal pain
- Anorectal pain/itching
- Black, tarry stools
- Bloating/gas
- Blood in stool
- Change in bowel habits
- Constipation
- Diarrhea
- Incontinence of stool
- Heartburn/reflux
- Difficulty swallowing
- Nausea
- Vomiting

Genitourinary None

- Blood in urine
- Dark urine
- Enlarged prostate
- Frequent urinary infections
- Heavy menstruation
- Pain/burning with urination
- Pregnancy
- Sexually transmitted disease
- Urinary incontinence
- Frequent urination

Integumentary/Skin None

- Itching
- Jaundice
- Rashes
- Suspicious lesions

Cardiovascular None

- Heart murmur
- Irregular heart beat
- Hand/ankle swelling
- Rapid heart rate/palpitations
- Chest pain

Neurological None

- Frequent headaches
- Memory loss/confusion
- Numbness or tingling

Endocrine None

- Cold intolerance
- Excessive thirst
- Heat intolerance

Constitutional None

- Chills
- Fatigue
- Fever
- Loss of appetite
- Night sweats
- Weight gain
- Weight loss

Psychiatric None

- Anxiety
- Bipolar disorder
- Depression

Ear/Nose/Mouth/Throat None

- Double vision
- Eye irritation
- Eye pain
- Eye redness
- Sore throat
- Hoarseness
- Mouth sores
- Nose bleeds
- Post-nasal drip
- Recurrent sinus infections

Hematologic/Lymphatic None

- Anemia
- Blood transfusions
- Easy bruising
- Prolonged bleeding

Musculoskeletal None

- Back pain
- Joint pain

Respiratory None

- Frequent cough
- Shortness of breath
- Snoring
- Sleep apnea
- Wheezing

Allergic/Immunologic None

- Allergies
- HIV exposure
- Immune deficiency

Reviewed with: Patient Parent Guardian Not present/telephone

Signature: _____

Date: _____



CONSENT FOR MEDICAL TREATMENT OF A MINOR
Form must be completed for all persons under the age of 18 years

The Texas Family Code allows only certain people to consent to medical treatment for minors if parental consent cannot be obtained. These are:

1. A grandparent
2. An adult sister or brother
3. An adult aunt or uncle
4. An educational institution in which your child is enrolled, which has written authorization to consent to treatment
5. Any adult who has care and control of the child and who has written authorization from the parent to consent to treatment.

I, _____, am

the parent

the guardian (specify relationship)

of the minor child, _____, and hereby authorize Texas Digestive Disease Consultants and/or its authorized agents, to consent to what ever medical treatment they may deem necessary while said minor is under their care in accordance with Texas Family Code Section 32.001.

Nature of expected medical treatment: Gastroenterology Specialist Care

Date treatment is expected to begin: _____

Parent/Guardian Name

Parent/Guardian Signature

Date



Limited Patient Authorization for Disclosure of Protected Health Information

Please print all information, then sign and date form.

| | | |
|---------------|-------------------------|------|
| Patient Name: | Social Security Number: | DOB: |
|---------------|-------------------------|------|

Who is Authorized to Receive Information:

I authorize Texas Digestive Disease Consultants to disclose or provide protected health information about me to the following person(s) or entity:

| | | |
|-------|----------------------|---------------|
| Name: | Telephone Number(s): | Relationship: |
| Name: | Telephone Number(s): | Relationship: |
| Name: | Telephone Number(s): | Relationship: |

Information to Be Disclosed:

I authorize Texas Digestive Disease Consultants to disclose or provide the following types of protected health information to the person(s) or entity identified above:

All Information about specialist care received
 All Diagnostic Test Results
 Lab Results Only
 Billing Statement of Charges for Care Only
 Other (specify): _____

Purpose of Disclosure:

The disclosure / use of the types of protected health information noted above is for the following purposes:

At my request
 To discuss with my family the care and treatment I receive
 Payment by 3rd party, other than health insurance
 Other (specify): _____

Expiration of this Authorization: This authorization will expire 1 year from the date of your signature below, unless you specify an earlier termination. You must submit a new authorization after the expiration date to continue authorization. You have the right to terminate this authorization at any time by notifying the TDDC Privacy Manager in writing. Please specify expiration date if less than 1 year: _____

Redisclosure: TDDC has no control over the person(s) or entity you have listed to receive your protected health information. Therefore, protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

Patient Signature

Date

Patient Signature

Date

Patient Signature

Date

TDDC

Texas Digestive Disease Consultants

Please remember, your child is our patient. Your child, the patient, must be present at all office appointments.

Your time is very important to us.

This office makes every effort to stay on schedule. We make certain that ample time is provided for each patient; both for appointments in our office and all of our procedures that are done at the surgery center.

We do not overbook patients; we allow each patient the quality time and consideration necessary for their healthcare needs. We do see patients with highly complex problems that often require additional time.

For this reason, our office requires 24 hours notice prior to cancelling or rescheduling an office appointment. We will be unable to reschedule patients that fail to show for a confirmed appointment. There is a \$25.00 cancellation/no show fee for not giving at least 24 hours notice prior to cancelling or rescheduling an appointment.

Procedure Policy:

There is a \$75 cancellation fee for not giving at least 48 hours notice prior to cancelling or rescheduling a procedure. Procedure payment is due 24 hours prior to the procedure or the procedure will be cancelled.

I warrant that I am the party responsible for making medical decisions for the child represented in this medical record. I acknowledge that payment is due at the time of service. I assume financial responsibility for any and all healthcare services provided to this patient. I understand that the provider of service will not get involved in matters involving third party personal billing whether result of custody, court order, or personal circumstances.

The parent/guardian who is accompanying the child to the visit is responsible for any payment due at the time services are rendered and any amount not covered by insurance including, without limitation, deductible, co-payment, co-insurance, or other amounts determined by my insurance company to be my responsibility and any collection/attorney fees incurred in collecting that balance.

Signature of parent or guardian

Date