TDDC
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: _____

_____

_____

_____

Past Medical History: ◯ None

Cancers: ◯ Colon ◯ Esophageal ◯ Liver ◯ Small Intestine ◯ Stomach
◯ Kidney ◯ Pancreas ◯ Bladder ◯ Lymphoma ◯ Lung
◯ Skin ◯ Prostate ◯ Breast ◯ Cervical ◯ Ovarian
◯ Uterine ◯ Other:_____

Liver: ◯ Fatty liver ◯ Hepatitis A, Active ◯ Hepatitis B, Active ◯ Hepatitis C, Active
◯ Hepatitis, Autoimmune ◯ Other: _____

Digestive: ◯ Acid Reflux ◯ Barrett's Esophagus ◯ Celiac Sprue
◯ Cirrhosis of Liver ◯ Colon Polyps ◯ Crohn's Disease
◯ Diverticulitis (Infected) ◯ Diverticulosis ◯ H. Pylori
◯ Irritable Bowel Syndrome ◯ Pancreatitis ◯ Ulcer
◯ Ulcerative Colitis ◯ Other:_____

Miscellaneous: ◯ Anxiety/Panic Attacks ◯ Arthritis ◯ Asthma ◯ Atrial Fibrillation
◯ Congestive Heart Failure ◯ Coronary Artery Disease ◯ Depression ◯ Diabetes
◯ Emphysema ◯ Endometriosis ◯ Fibromyalgia ◯ Glaucoma
◯ Heart Attack ◯ High Blood Pressure ◯ High Cholesterol ◯ HIV
◯ Kidney Disease ◯ Lupus ◯ Osteopenia ◯ Osteoporosis
◯ Seizure Disorder ◯ Sleep Apnea ◯ Stroke/TIA ◯ Thyroid, Overactive
◯ Thyroid, Underactive ◯ Other: _____

Previous Gastroenterology Procedures: ◯ None
◯ Colonoscopy ◯ EGD/Upper Endoscopy ◯ ERCP ◯ Endoscopic Ultrasound/EUS
◯ Small Bowel Capsule ◯ Other: _____

Surgical Procedures: ◯ None
◯ Appendectomy ◯ C-Section ◯ Cataract Surgery ◯ Colon Resection ◯ Coronary Artery Bypass
◯ Coronary/Stent ◯ Defibrillator ◯ Gallbladder Removed ◯ Gastric Bypass ◯ Heart Valve Replacement/Repair
◯ Hemorrhoidectomy ◯ Hiatal Hernia Surgery (for Reflux) ◯ Hysterectomy, Partial (Ovaries Intact)
◯ Hysterectomy, Total (Ovaries Removed) ◯ Inguinal Hernia Surgery (Groin)
◯ Joint Surgery/Replacement ◯ Lap Band ◯ Liver Transplant ◯ Mastectomy
◯ Pacemaker ◯ Prostatectomy ◯ Tonsillectomy ◯ Tubal Ligation
◯ Ulcer Surgery ◯ Umbilical Hernia Surgery (Belly-Button)
◯ Other: _____ ◯ Other: _____

Social History: **Occupation:** _____

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Separated ◯ Widowed ◯ Other

Alcohol: ◯ None ◯ Less than 7drinks per week ◯ More than 7 drinks per week ◯ I quit using alcohol

Tobacco/Smoking Status: ◯ Current, every day smoker ◯ Current, some day smoker ◯ Former smoker ◯ Never smoked
◯ Smoker, current status unknown ◯ Unknown if ever smoked ◯ Chewing Tobacco/Snuff ◯ Cigar/Pipe Smoker

Drug Use: ◯ None
◯ I have used recreational drugs in the past ◯ I am currently using recreational drugs ◯ I have been treated for substance abuse

Family Medical History: ◯ Unknown/Adopted ◯ No family history of colon cancer ◯ No family history of colon polyps

Diagnosis	Mother	Father	Sister	Brother	Daughter	Son	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Maternal Aunt	Maternal Uncle	Paternal Aunt	Paternal Uncle	Other	Age at Diagnosis
Colon Cancer	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	_____
Colon Polyps	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	_____
Crohn's/Colitis	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	_____
Liver Disease	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	_____
Uterine Cancer	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	_____
Kidney Cancer	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	_____
Stomach Cancer	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	_____
Bladder Cancer	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	_____
Pancreatic Cancer	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	_____
Ovarian Cancer	◯		◯		◯		◯		◯		◯		◯		◯	_____

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:** _____

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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

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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