MEDICAL SPECIALISTS OF NORTH ALABAMA

PATIENT DATA
FORM MUST BE COMPLETED IN FULL

Today's Date _____

Name _____

Mailing Address _____
Street City State Zip

Date of birth:_____ Patient's SSN_____ Gender ☐ Male ☐ Female

Phone Numbers: Home _____ Cell _____ Work_____

Preferred contact number? ☐ Home ☐ Cell ☐ Work May we leave messages on your voicemail? ☐ Yes ☐ No

Email Address_____

Preferred language: ☐ English ☐ Spanish ☐ Other_____

Race: ☐ American indian/Alaskan native ☐ Asian ☐ Black/African American
☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other race ☐ Unknown ☐ Declined

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Declined

Emergency contact: _____
Name Relationship Phone

INSURANCE/GUARANTOR INFORMATION

Policy Holder's Name_____ Policy Holder Date of Birth _____

Name of Primary Insurance _____ Name of Secondary Insurance _____

Patient'sEmployer_____

Referring Dr_____ Primary Care Dr_____

Preferred Pharmacy_____
Name City Phone

Have you had a colonoscopy in the past 10 years? ☐ Yes ☐ No

Have you had an EGD (exam of esophagus and stomach) in the past 10 years? ☐ Yes ☐ No

If yes:_____Physicians name_____
City/State

MEDICAL SPECIALISTS OF NORTH ALABAMA

GUNTERSVILLE OFFICE PHONE: 256-571-8810
Arab area residents: 256-753-8810
FAX: 256-571-8880

BOAZ OFFICE PHONE: 256-840-4840
FAX: 256-840-4844

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Medical Specialists of North Alabama's Notice of Privacy Practices. By signing below I am only giving acknowledgement that I have received or have had the opportunity to receive the Notice of Privacy Practices.

_____

Patient Name (Printed)

Signature: _____ **Date:** _____

RELEASE OF INFORMATION AUTHORIZATION:

Due to federal privacy guidelines (HIPPA), Medical Specialists of North Alabama is not allowed to divulge information to anyone other than the patient (or guardian of the patient) unless explicit written authorization is given to discuss personal medical information with someone other than you.

I, _____, give Medical Specialists of North Alabama permission to release / discuss personal medical information to include the pickup of prescriptions and / or financial information to:

Name: _____ **Relationship to Patient:** _____

Name: _____ **Relationship to Patient:** _____

Signature: _____ **Date:** _____

GUARANTEE OF ACCOUNT: MUST BE 19 YEARS OF AGE TO SIGN

I, the undersigned, directly assign to Medical Specialists of North Alabama all surgical and / or medical benefits, if any, otherwise payable to me for services rendered.

In consideration of services rendered or to be rendered, the undersigned agrees to pay all costs of collection and / or reasonable attorney fees, should the account be turned over to enforce collections of said charges.

I hereby authorize Medical Specialists of North Alabama to release any information necessary to secure payment of benefits to my account.

Signature: _____ **Date:** _____

MEDICAL SPECIALISTS OF NORTH ALABAMA

OFFICE POLICY

We are grateful you have chosen our practice to provide you with gastroenterology care. Please carefully read over the following policies, initial, sign and date.

Please Initial

Cell phone use As a courtesy to others, we request you turn off your cell phone while in clinical areas.	
Fees Patients are expected to pay all co-pays at the time of your visit.	
Nurse calls & questions The receptionist will take your name, number and reason for your call. Calls will be returned by the end of the next business day.	
Appointment Times Please arrive early for your scheduled appointment. If you are late you will be asked to reschedule.	
Cancellations The office requests 24 hour notice prior to your scheduled appointment time. If you cancel or fail to come for 3 appointments, we reserve the right to NOT reschedule any future appointments.	
No Show/Rescheduling Patient's that NO SHOW for 3 appointments or reschedule 3 consecutive appointments are subject to dismissal from our practice for non-compliance.	
Treatment adherence Taking your medicine as prescribed is vital for controlling chronic conditions and overall long-term health and well-being. Certain chronic diseases and medications or infusions require close laboratory monitoring. Failure to have required testing and/or scheduled infusions is considered non-compliance and is subject to dismissal from the practice.	
Form completion There is a 5 business day turnaround time for FMLA or other forms needing completion. There is a $20 charge per form.	

These policies enable us to better serve you, our patient. Please sign below that you have read and agree to the above guidelines.

_____ _____ / _____ / _____ _____ / _____ / _____

Patient Signature *Date of Birth* Today's Date

MEDICAL SPECIALISTS OF NORTH ALABAMA

PERSONAL HISTORY

Today's date_____

Name_____ DOB_____

Other physicians involved in your healthcare _____

DESCRIBE the reason(s) for your vistit _____

1. Have you travelled outside the United States in the past 6 months? ☐ Yes ☐ No
2. **PATIENT MEDICAL HISTORY**
   Check all that apply.

☐ **Cirrhosis**
☐ **Colon Cancer**
☐ **Colon Polyps**
☐ **Constipation**
☐ **Crohn's Disease**
☐ **Diverticulosis**
☐ **GERD/Reflux**
☐ **Hepatitis B**
☐ **Hepatitis C (HCV)**
☐ **Hiatal Hernia**
☐ **Irritable Bowel Syndrome**
☐ **Liver disease**
☐ **Pancreatitis**
☐ **Stomach/Intestinal Ulcers**
☐ **Ulcerative Colitis**
☐ Anemia
☐ Anxiety/Depression
☐ Arthritis
☐ Asthma
☐ Cancer: Type_____
☐ Congestive Heart Failure (CHF)
☐ COPD/Emphysema
☐ Coronary Artery Disease (CAD)
☐ Diabetes
☐ Heart Attack
☐ HIV/AIDS
☐ Hyperlipidemia/Cholesterol
☐ Hypertension/HBP
☐ Hypothyroidism
☐ Kidney Disease
☐ Migraines
☐ Sleep Apnea
☐ Seizures
☐ Stroke (CVA)
☐ TIA (Mini-stroke)
☐ Other_____
_____

3. **VACCINES**
Have you ever had a Pneumococcal (pneumonia) Vaccine? ☐ Yes ☐ No

Have you ever had the following vaccines? ☐ Influenza (Flu) ☐ Hepatitis A ☐Hepatitis B

4. **SURGICAL HISTORY**
   Check all that apply.

☐Colon Surgery
☐Hemorrhoid Surgery
☐Gallbladder Surgery
☐Gastric Surgery
☐Liver Surgery
☐Hiatal Hernia Surgery
☐Small Intestine Surgery
☐Appendectomy
☐Brain Surgery
☐Breast Surgery
☐C-Section
☐CABG/Heart surgery
☐Defibrillator
☐Heart Stents
☐Hernia Surgery
☐Hysterectomy
(Abdominal or Vaginal)
☐Joint replacement
☐Laparoscopy
☐Obesity Surgery,
Type_____
☐Pacemaker
☐Prostate Surgery
☐Spinal surgery
☐Thyroidectomy
☐Transplant surgery
☐Tubal Ligation
☐Valve Replacement surgery
☐Vascular Stents,
Location_____
☐Other_____
_____

continue to the next page

Name_____ DOB_____

5. **MEDICATIONS** List current medications (including Herbal and Over the Counter)

Drug	Strength	Dose

Drug	Strength	Dose

Are you currently taking any blood thinners? ☐ Brilinta ☐ Coumadin ☐ Plavix ☐ Warfarin ☐ Xarelto ☐ Effient ☐ Other_____

Are you currently taking any of the following aspirin/NSAIDs? ☐ Advil ☐ Aleve ☐ Aspirin ☐ BC Powder ☐ Excedrin ☐ Goody powder ☐ Ibuprofen ☐ Naprosyn ☐ Fish Oil

6. **ALLERGIES**

List any medication allergies. ☐ No known medication allergies

_____ _____ _____

_____ _____ _____

7. **FAMILY HISTORY** Check all that apply

	Mother	Father	Brother	Sister	Grandmother	Grandfather
Barrett's Esophagus	☐	☐	☐	☐	☐	☐
Colon Polyps	☐	☐	☐	☐	☐	☐
Crohn's Disease	☐	☐	☐	☐	☐	☐
Ulcerative Colitis	☐	☐	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
CANCERS						
Breast	☐	☐	☐	☐	☐	☐
Colon	☐	☐	☐	☐	☐	☐
Esophagus	☐	☐	☐	☐	☐	☐
Pancreas	☐	☐	☐	☐	☐	☐
Stomach	☐	☐	☐	☐	☐	☐

8. **SOCIAL HISTORY** Provide detail regarding current and/or past use of the following:

Alcohol (beer, wine, liquor) ☐ Yes ☐ No Usage_____

I.V. or Recreational Drugs ☐ Yes ☐ No Usage_____

Tobacco (cigarettes, cigars, chewing tobacco) ☐ Yes ☐ No Usage_____

Caffeine Use (coffee, tea, soda, energy drinks) ☐ Yes ☐ No Usage_____

Date of last menstrual period _____

MEDICAL SPECIALISTS OF NORTH ALABAMA

BOAZ OFFICE
2525 HIGHWAY 431, SUITE 220
PHONE: 256-840-4840
FAX: 256-840-4844

Please Print

Patient Full Name: _____ **Date of Birth:** _____

Patient Address: _____

City: _____ State: _____ Zip: _____ Phone #: _____

Authorization to Release Protected Health Information

I understand that:

- ✓ I may refuse to sign this authorization and that it is strictly voluntary.
- ✓ My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
- ✓ I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
- ✓ **Unless otherwise revoked, this authorization will expire on the following date, event or condition:** _____. *If I do not specify expiration this authorization will not expire.*
- ✓ I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.
- ✓ I understand that I may see and obtain a copy of the information described in this form, for a reasonable copy fee, if I ask for it.
- ✓ I can request a copy of this form after I sign and date it.

If applicable, I also give permission for the following to be disclosed (please initial):

____ acquired immunodeficiency syndrome (AIDS) or infection with human immunodeficiency virus (HIV)
____ behavioral health services/psychiatric care
____ treatment for alcohol and/or drug abuse

Signature*: _____ **Date:** _____

**For non-emancipated minors under the age of 19 years, a parent or guardian must sign release form. If patient is unable to sign a copy of the legal documentation for patient's representative must be supplied with a copy of this form.*

• OFFICE USE ONLY •

Release Information To Medical Specialists of North Alabama PLEASE FAX TO: 256-840-4844

Released From: _____ **Fax Number:** _____

Date Range: _____

☐ Office Notes ☐ Radiology Reports ☐ Labs ☐ Operative Reports ☐ Compete Medical Record

☐ Complete Hospital Record ☐ Pathology Reports ☐ Other: _____

Release Information From Medical Specialists of North Alabama To:

Name / Facility: _____ **Attention:** _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ **Fax #:** _____

Purpose of Request: ☐ Personal ☐ Treatment ☐ Legal ☐ Insurance ☐ Transfer ☐ Other: _____