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's Employer____

Referring Dr___________________________________ Primary Care Dr__________________________

Preferred Pharmacy: ____
Name City Phone

Have you had a colonoscopy in the past 10 years? ☐ No ☐ Yes – What year? _________

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

If yes: ___________________________________ Physician/Hospital Name ______________________
City/State

Benjamin Shepard, DO
2525 US Hwy 431, Suite 220
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Tel: (256) 840-4840
Fax: (256) 840-4844

Chad Sisk, DO
7938 AL Hwy 69, Suite 310
Guntersville, AL 35976
Tel: (256) 571-8600
Fax: (256) 571-8640

Winter Wilson, DO
55 Rowe Drive, Suite C
Guntersville, AL 35976
Tel: (256) 571-8810
Fax: (256) 571-8880

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to recieve a copy of Medical Specialists of North Alabam'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 (HIPAA), 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 visit ________________________________

1. **PATIENT MEDICAL HISTORY** *Check all that apply.*

- ☐ **Celiac Disease**
- ☐ **Cirrhosis**
- ☐ **Cologuard - Date:** __________
- ☐ **Colon Cancer**
- ☐ **Colon Polyps**
- ☐ **Constipation**
- ☐ **Crohn's Disease**
- ☐ **Diarrhea**
- ☐ **Diverticulosis**
- ☐ **Fit Test - Date:** ___________
- ☐ **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
- ☐ Atrial Fibrillation (AFib)
- ☐ Autoimmune
  Condition: ________________
- ☐ Cancer
  Type: ____________________
- ☐ Congestive Heart Failure (CHF)
- ☐ COPD/Emphysema
- ☐ Coronary Artery Disease (CAD)
- ☐ Diabetes
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Hyperlipidemia/Cholesterol
- ☐ Hypothyroidism
- ☐ Kidney Disease
- ☐ Migraines
- ☐ Prostate Issues
- ☐ Sleep Apnea
- ☐ Seizures
- ☐ Stroke (CVA)
- ☐ TIA (Mini-stroke)
- ☐ Other________________
  ____

2. **CURRENT HEIGHT:** ____________________

3. **CURRENT WEIGHT:** ____________________

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
- ☐ Thyroid Surgery
- ☐ 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						
Colon	☐	☐	☐	☐	☐	☐
Esophagus	☐	☐	☐	☐	☐	☐
Pancreas	☐	☐	☐	☐	☐	☐
Stomach	☐	☐	☐	☐	☐	☐

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

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

I.V., Recreational Drugs or THC/CBD ☐ Yes ☐ No Usage________________

Tobacco (cigarettes, vape, e-cigs, chewing tobacco) ☐ Yes ☐ No Usage________________

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

Date of last menstrual period ________________

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Authorization to Release Protected Health Information

Patient Full Name: ____________________ DOB: ____ / ____ / ____

Patient Address: ____________________

City: ____________ State: ____ Zip: ______ Phone #: ____________

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 authrorization.
- ✓ 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 supllied with a copy of this form.*

Release Information TO Medical Specialists of North Alabama — Please FAX to: 256.840.4844

Release From: ____________________ Fax #: ____________

Date Range: ____________________

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

☐ Complete Hospital Record ☐ Pathology Reports ☐ Other: ____________

Release Information FROM Medical Specialists of North Alabama

Name / Facility: ____________________ Attention: ____________

Address: ____________________ Phone: ____________

City: ____________ State: ____ Zip: ______ Fax: ____________

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