



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



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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 (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

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*

<p><b><u>Cell phone use</u></b> As a courtesy to others, we request you turn off your cell phone while in clinical areas.</p>	
<p><b><u>Fees</u></b> Patients are expected to pay all co-pays at the time of your visit.</p>	
<p><b><u>Nurse calls &amp; questions</u></b> The receptionist will take your name, number and reason for your call. Calls will be returned by the end of the next business day.</p>	
<p><b><u>Appointment Times</u></b> Please arrive early for your scheduled appointment. If you are late you will be asked to reschedule.</p>	
<p><b><u>Cancellations</u></b> 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.</p>	
<p><b><u>No Show/Rescheduling</u></b> Patient's that NO SHOW for 3 appointments or reschedule 3 consecutive appointments are subject to dismissal from our practice for non-compliance.</p>	
<p><b><u>Treatment adherence</u></b> 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.</p>	
<p><b><u>Form completion</u></b> There is a 5 business day turnaround time for FMLA or other forms needing completion. There is a \$20 charge per form.</p>	

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



**DATOS DEL PACIENTE**  
EL FORMULARIO DEBE  
COMPLETARSE EN SU TOTALIDAD

Fecha de hoy \_\_\_\_\_

Nombre \_\_\_\_\_

Dirección postal \_\_\_\_\_  
Calle Ciudad Estado Código Postal

Fecha de nacimiento: \_\_\_\_\_ Número de Seguro Social del paciente \_\_\_\_\_ Género  Masculino  
 Femenino

Teléfonos: Casa \_\_\_\_\_ Celular \_\_\_\_\_ Trabajo \_\_\_\_\_

¿Cuál es su número de contacto preferido?  Casa  Celular  Trabajo ¿Podemos dejarle mensajes en su buzón de voz?  Sí  No

Correo electrónico: \_\_\_\_\_

Idioma preferido:  Inglés  Español  Otro \_\_\_\_\_

Raza:  Indígena americano/nativo de Alaska  Asiático  Negro/afroamericano  
 Nativo de Hawái/Otro isleño del Pacífico  Blanco  Otra raza  Desconocido  No contestado

Etnia:  Hispano o latino  No contestado o latino  No contestado

Contacto de emergencia: \_\_\_\_\_  
Nombre Parentesco Teléfono

**INFORMACIÓN DEL SEGURO/GARANTE**

Nombre del titular de la póliza: \_\_\_\_\_ Fecha de nacimiento del titular de la póliza: \_\_\_\_\_

Nombre de la compañía de seguros principal: \_\_\_\_\_ Nombre de la compañía de seguros secundaria: \_\_\_\_\_

Empleador del paciente: \_\_\_\_\_

Médico remitente: \_\_\_\_\_ Médico de atención primaria: \_\_\_\_\_

Farmacia preferida: \_\_\_\_\_  
Nombre Ciudad Teléfono

¿Se ha realizado una colonoscopia en los últimos 10 años?  No  Sí – ¿Qué año? \_\_\_\_\_

¿Se ha realizado una endoscopia esofágica (EGD) en los últimos 10 años?  No  Sí – ¿Qué año? \_\_\_\_\_

En caso afirmativo: \_\_\_\_\_ Nombre del médico/hospital \_\_\_\_\_  
Ciudad/Estado

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon Polyps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>CANCERS</b>						
Colon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Esophagus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pancreas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**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 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:
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.

Release Information TO Medical Specialists of North Alabama Please FAX to: 256.571.8640

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: