



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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Tel: (256) 571-8810
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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><u>Cell phone use</u> As a courtesy to others, we request you turn off your cell phone while in clinical areas.</p>	
<p><u>Fees</u> Patients are expected to pay all co-pays at the time of your visit.</p>	
<p><u>Nurse calls & questions</u> 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><u>Appointment Times</u> Please arrive early for your scheduled appointment. If you are late you will be asked to reschedule.</p>	
<p><u>Cancellations</u> 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><u>No Show/Rescheduling</u> 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><u>Treatment adherence</u> 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><u>Form completion</u> 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

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.*

- | | | |
|---|---|---|
| <input type="checkbox"/> Celiac Disease | <input type="checkbox"/> Stomach/Intestinal Ulcers | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Hyperlipidemia/Cholesterol |
| <input type="checkbox"/> Cologuard - Date: _____ | <input type="checkbox"/> Anemia | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Anxiety/Depression | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Colon Polyps | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Asthma | <input type="checkbox"/> Prostate Issues |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Atrial Fibrillation (AFib) | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Autoimmune | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Diverticulosis | Condition: _____ | <input type="checkbox"/> Stroke (CVA) |
| <input type="checkbox"/> Fit Test - Date: _____ | <input type="checkbox"/> Cancer | <input type="checkbox"/> TIA (Mini-stroke) |
| <input type="checkbox"/> GERD/Reflux | Type: _____ | |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Congestive Heart Failure (CHF) | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Hepatitis C (HCV) | <input type="checkbox"/> COPD/Emphysema | _____ |
| <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Coronary Artery Disease (CAD) | |
| <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Diabetes | |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> Heart Attack | |
| <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> High Blood Pressure | |

2. **CURRENT HEIGHT:** _____

3. **CURRENT WEIGHT:** _____

4. SURGICAL HISTORY *Check all that apply.*

- | | | |
|--|--|--|
| <input type="checkbox"/> Colon Surgery | <input type="checkbox"/> Defibrillator | <input type="checkbox"/> Thyroid Surgery |
| <input type="checkbox"/> Hemorrhoid Surgery | <input type="checkbox"/> Heart Stents | <input type="checkbox"/> Transplant surgery |
| <input type="checkbox"/> Gallbladder Surgery | <input type="checkbox"/> Hernia Surgery | <input type="checkbox"/> Tubal Ligation |
| <input type="checkbox"/> Gastric Surgery | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Valve Replacement surgery |
| <input type="checkbox"/> Liver Surgery | (Abdominal or Vaginal) | <input type="checkbox"/> Vascular Stents, |
| <input type="checkbox"/> Hiatal Hernia Surgery | <input type="checkbox"/> Joint replacement | Location _____ |
| <input type="checkbox"/> Small Intestine Surgery | <input type="checkbox"/> Laparoscopy | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Obesity Surgery, | _____ |
| <input type="checkbox"/> Brain Surgery | Type _____ | _____ |
| <input type="checkbox"/> Breast Surgery | <input type="checkbox"/> Pacemaker | |
| <input type="checkbox"/> C-Section | <input type="checkbox"/> Prostate Surgery | |
| <input type="checkbox"/> CABG/Heart surgery | <input type="checkbox"/> Spinal surgery | |

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"/>
CANCERS						
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: 256.571.8880

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: