PREMIER GASTROENTEROLOGY, PA

PATIENT INFORMATION:_____ TODAY'S DATE:_____

First Name: _____ MI: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Tel: # (Home) _____ (Work)_____

Social Security # _____-_____-_____ Date of 1ST visit: / / 20

Date of Birth: / / Sex: (M) _____ (F) _____ Marital status: _____

Do you have an Advanced Directive (living will) Yes No

Email address: _____

CONTACT INFORMATION

Please print the telephone number where you want to receive calls about your appointments, follow-up, test results or other health care information:

Phone Number: _____ Back-up: _____

I am fully aware that a cell phone is not a secure and private line.

Person to notify in case of emergency: _____Phone # _____

GUARANTOR INFORMATION: (PERSON FINANCIALLY RESPONSIBLE)

Same as above _____

First Name: _____ MI: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Tel. # (Home) ( )_____-_____ (Work) ( )_____-_____

SS# _____-___-_____ DOB: _____

INSURANCE INFORMATION

PRIMARY INSURANE COMPANY NAME: _____ POLICY HOLDERS NAME:_____
Address_____ Policy Number _____Group # _____

SECONADRY INSURANCE COMPANY NAME: _____POLICY HOLDERS NAME_____
Address_____ Policy Number _____Group # _____

PRIMARY CARE PHYSICIAN:

NAME:_____ PHONE NUMBER:_____

PHARMACY NAME/LOCATION:

NAME:_____LOCATION_____PHONE #_____

CIRCLE ONE IN EACH OF THE FOLLOWING CATEGORIES

Marital Status: Single Married Divorced Widowed Legally Separated Partner

Employment: Full Time Part Time Self-Employed Retired Active Duty Military Unemployed

Student: Full Time Part Time

***Race**: White Black or African American American Indian or Alaska Native Asian Native Hawaiian Other Pacific Other Refuse to report

***Ethnicity**: Hispanic or Latino Not Hispanic or Latino Refuse to report

***Primary Language**: _____

*** Required info**

AFFIDAVIT

MY SIGNATURE BELOW INDICATES THAT I HEREBY VOLUNTARILY CONSENT TO ANY AND ALL OF THE MEDICAL SERVICE PROVIDED TO ME BY PREMIER GASTROENTEROLOGY AND DR. HIBA. I ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE TO ME AS A RESULT OF EXAMINATION OR TREATMENT PROVIDED.

I AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, REGARDLESS OF MY INSURANCE STATUS, AND THAT PREMIER GASTROENTEROLOGY WILL BILL MY INSURANCE AS A COURTESY ONLY. I AGREE THAT THERE WILL BE A $ 25 CHARGE FOR NO-SHOWS OR SAME DAY CANCELLATIONS.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO VERIFY AND UNDERSTAND MY HEALTH INSURANCE POLICY *PRIOR* TO RECEIVING THE MEDICAL SERVICES PROVIDED. IF PAYING BY CHECK(S), I UNDERSTAND THAT THERE IS A $ 35.00 FEE FOR ANY RETURNED CHECK. FURTHER, I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY FOR MY INSURANCE OR REIMBURSEMENT CONCERNS.

I AUTHORIZE (ASSIGN) INSURANCE CARRIER(S)/MEDICARE TO MAKE PAYMENT DIRECTLY TO PREMIER GASTROENTEROLOGY FOR SERIVES RENDERED. I AUTHORIZE PREMIER GASTROENTEROLOGY TO SUBMIT A CLAIM ON MY BEHALF TO MY INSURANCE FOR PAYMENT TO PREMIER GASTROENTEROLOGY. I UNDERSTAND AND AGREE (REGARDLESS OF MY INSURANCE STATUS), THAT I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF ANY PROFESSIONAL SERVICES RENDERED.

I AM SOLELY RESPONSIBLE FOR ANY ITEM(S) I CHOOSE TO BRING WITH ME INTO THE PREMISES OF PREMIER GASTROENTEROLOGY.

I CERTIFY THAT THE INFORMATION I HAVE GIVEN HERE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL ALSO NOTIFY YOU OF ANY CHANGES IN MY STATUS OR CHANGES IN THE ABOVE INFORMATION. FINALLY, I HAVE RECEIVED A COPY OF PREMIER GASTROENTEROLOGY PRIVACY NOTICE AS REQUIRED BY HIPAA

_____ _____

I AGREE AND ACCEPT THE ABOVE TERMS **DATE**

Premier Gastroenterology PA

CONSENT TO DISCLOSE MEDICAL INFORMATION

Patient Name:_____**DOB:**_____

Please check one of the following:

_____I give my permission to the employees of Premier Gastroenterology to disclose my Protected Health Information to me and the following family or friends:

Name:_____Relation:_____Phone:_____

Address:_____

Name:_____Relation:_____Phone:_____

Address:_____

Name:_____Relation:_____Phone:_____

Address:_____

Name:_____Relation:_____Phone:_____

Address:_____

____I request that all my Protected Health Information be disclosed ONLY to me and no other family or friends.

I understand that I may revoke or change this Consent at any time by filling out another consent form to replace this one.

_____Date:_____

Patient Signature

_____

Patient- Print Name

Premier Gastroenterology, PA
M. Rodwan Hiba, MD
Required Signatures

Consent for Treatment:

My signature below indicates that I hereby consent to any recommended medical service provided to me by Premier Gastroenterology, PA and Dr. M. Rodwan Hiba. I acknowledge that no guarantees have been made to me as a result of examination or treatment provided.

Insurance Statement (All Insurances):

I understand that as a courtesy Premier Gastroenterology, PA will bill my insurance carrier for services rendered. I request that payment of authorized insurance benefits be made on my behalf to Premier Gastroenterology, PA for any services furnished. I authorize any holder of medical information about me be released to the insurance carrier/Health Care Finance Administration and it's agents to determine benefits payable for related services. I also request that payment for authorized Medigap/Secondary insurance carrier benefits be made on my behalf to Premier Gastroenterology, PA. I authorize any holder of medical information about me be released to the Medigap/Secondary insurance carrier and it's agents to determine benefits payable for related services. I understand that I do not need to provide my Medigap/Secondary insurance carrier with information concerning Medicare claims because my signing this authorization will allow Medicare payment information to cross-over automatically.

All Patients (Required):

I understand that I am financially responsible and agree to all charges for myself and for the members of my family, as applicable, promptly upon presentation thereof. ***I understand that payment of copays, coinsurance and deductibles are due at the time of service and that if I am unable to do so, then my appointment may be rescheduled.*** **I understand that it is my responsibility to verify and understand my insurance policy PRIOR to receiving the medical services provided. If paying by check, I understand that there is a $35.00 fee for any returned check. Charges as shown by statements are agreed to be correct unless protested in writing within thirty days of date of service. It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims theron. In the event that legal action should become necessary to collect unpaid balance due, I agree to pay reasonable attorney's fees and other such costs as determined by the Hernando County Court. I UNDERSTAND AND AGREE THERE WILL BE A $35.00 NO SHOW FEE FOR OFFICE VISITS NOT CANCELLED WITHIN 24 HOURS. IN ADDITION, THERE WILL BE A $75.00 NO SHOW FEE FOR PROCEDURES NOT CANCELLED WITHIN 36 HOURS OF THE PROCEDURE.**

Rx: History Consent:

I hereby give Premier Gastroenterology, PA permission to view my prescription information and history from all external sources. By signing this consent form you are agreeing that Premier Gastroenterology can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for all treatment purposes.

Understanding all of the above, I hereby provide informed consent to Premier Gastroenterology, PA.

_____ _____

Patient's Signature/ Representative **Date**

_____

Print Name

Premier Gastroenterology, PA *M. Rodwan Hiba, MD*
American Board Certified in Internal Medicine & Gastroenterology

12102 Cortez Blvd
Brooksville, Florida 34613
(352) 597-4000
Fax (352) 597-0550

To: _____

_____

_____

I hereby authorize you to release any medical information, including but not limited to, examinations, diagnosis, and medical records of any treatment rendered to me to:

Dr. M. Rodwan Hiba
Premier Gastroenterology, PA
12102 Cortez Blvd
Brooksville, Florida34613

_____ _____
PATIENT SIGNATURE **GUARDIAN SIGNATURE (IF MINOR)**

_____ _____
WITNESS **DATE**

Patient name _____

Social Security Number_____ Date of Birth _____

Please Provide Photocopies of:

- ❑ All records (any patient diagnostic medical information, as well as, H & P, consultation, operative reports, discharge summery, etc.
- ❑ EKG
- ❑ Laboratory
- ❑ Mammogram(s)
- ❑ X-ray
- ❑ Other _____

_____

Premier Gastroenterology, PA *M. Rodwan Hiba, MD*

American Board Certified in Internal Medicine & Gastroenterology

12102 Cortez Blvd
Brooksville, Florida 34613
(352) 597-4000

WHAT BROUGHT YOU TO SEE THE DOCTOR TODAY?

_____

_____

WHEN DID THE SYMPTOMS START?_____

WHAT MAKES THE SYMPTOMS BETTER?_____

WHAT MAKES THE SYMPTOMS WORSE?_____

PREVIOUS TREATMENT:

EMERGENCY ROOM: _____**YES** _____**NO** **WHERE?**_____

DOCTOR'S OFFICE: _____**YES** _____**NO** **WHERE?**_____

ALLERGIES: Please check any allergies that apply to you

☐ **No known drug allergies**

Are you allergic to: ❑**Latex** ❑**Penicillin** ❑**Sulfa** ❑**Iodine** ❑**Tetanus** ❑**Other?**_____

What are the complications from your allergy?

❑**Nausea** ❑**Hives** ❑**Rash** ❑**Swollen Throat** ❑**Difficulty Breathing** ❑**Other:** _____

SOCIAL HISTORY

Do you live: _____Alone _____with Family _____Other:_____

Religion:_____ Marital Status: *Married* *Single* *Widowed* *Divorced* _____

Please indicate **TOBACCO USE**: _____None

_____Cigarettes: _____packs per day _____years of use Quit:_____(please list year)

_____Other (Cigar/Snuff)_____frequency/day _____years of use Quit:_____(please list year)

Please indicate **ALCOHOL USE:** _____None

How many glasses/cans do you drink _____daily _____weekly _____occasionally

Do you have a history of alcoholism or heavy alcohol intake? _____yes _____no

CHECK ALL DISEASES THAT HAVE OCCURED IN <u>YOUR FAMILY</u> and <u>INDICATE FAMILY MEMBER AFFECTED</u> (mother, father, sister, brother, grandparents, etc.)

Anemia	Breast Cancer	Cirrhosis of Liver	Colon Polyps	Colorectal Cancer
Crohn's Disease	Diabetes, (takes pills)	Diabetes, Insulin Dependent	Gastric Cancer	Gallstones
Heart Disease	Hemochromatosis	Irritable Bowel Syndrome	Liver Disease	Gynecological Ca
Pancreatic Cancer	Acute Pancreatitis	Chronic Pancreatitis	Peptic Ulcer Disease	Ulcerative Colitis
Other:				

PAST MEDICAL HISTORY: Do ***YOU*** now, or have ***YOU*** ever had any of the following illnesses, check all that apply.

CANCER
_____Colon Cancer
_____Cervical Cancer
_____Esophageal Cancer
_____Stomach Cancer
_____Breast Cancer
_____Pancreatic Cancer
_____Endometrial Cancer (uterus)
_____Liver Cancer
_____Leukemia
_____Lymphoma

RENAL
_____Kidney Stones
_____Kidney Failure
_____Dialysis

MUSCULOSKELETAL
_____Fibromyalgia
_____Osteoarthritis
_____Rheumatoid Arthritis
_____Raynaud's
_____Lupus
_____Sjogren
_____Scleroderma
_____Gout

PSYCHOLOGICAL
_____Bipolar
_____Anxiety
_____Depression
_____Obsessive Compulsive Disorder
_____Schizophrenia

LIVER
_____Hemochromatosis
_____Cirrhosis
_____Hepatitis A
_____Hepatitis B
_____Hepatitis C
_____Jaundice
_____Fatty Liver

HEART
_____High Blood Pressure (Hypertension)
_____Heart Attack (Myocardial Infarction)
_____Angina
_____Congestive Heart Failure
_____Palpitations
_____Mitral Valve Prolapse
_____Elevated Triglycerides
_____Elevated Cholesterol
_____Rheumatic Fever
_____Heart Valve Disease
_____Endocarditis
_____Abnormal Heart Rhythm

BLOOD
_____VonWillebrands'
_____Hemophilia
_____Bleeding or clotting abnormalities
_____Anemia

INTEGUMENTARY
_____Eczema
_____Skin Cancer
_____Melanoma
_____Psoriasis

NEUROLOGICAL
_____Stroke
_____Seizures
_____Migraines
_____Other Headache

RESPIRATORY
_____COPD (Emphysema)
_____Asthma
_____Tuberculosis (TB)
_____Sleep Apnea
_____Collapsed Lung

GASTROINTESTINAL
_____IBS-Irritable Bowel Syndrome
_____Diverticulitis
_____Diverticulosis
_____Peptic Ulcer Disease
_____Angiodysplasia of GI tract
_____Reflux
_____IBD-Crohn's
_____IBD-Ulcerative Colitis
_____Pancreatitis
_____Barrett's Esophagus
_____Colon Polyps

ENDOCRINOLOGY
_____Diabetes, Type I (insulin needed)
_____Diabetes, Type II (pills needed)
_____Thyroid Disease

SURGERIES and PROCEDURES: INDICATE THE DATE OF ANY SURGERIES YOU HAVE HAD

GASTROINTESTINAL
_____Appendectomy
_____Hiatal Hernia Repair
_____Cholecystectomy (Gallbladder Removal)
_____Surgery for Intestinal Adhesions
_____Gastric Bypass
_____Colon Surgery, partial
_____Gastric Surgery
_____Splenectomy (removal of spleen)
_____Hernia Type:_____
_____Colonoscopy
_____Upper Endoscopy (EGD)
_____ERCP
_____Pancreatic Surgery

GYNECOLOGICAL
_____Hysterectomy (Uterus Removed)
_____Ovary Removal (Oophorectomy)
_____Right_____Left_____Both
_____C-Section
_____Mastectomy (Breast Surgery)
_____Right_____Left_____Both

GU
_____TURP
_____Bladder Surgery
_____Cystectomy with Ileal conduit
_____Kidney Removal (nephrectomy)
_____Prostate Removal (prostatectomy)
_____Radiation for prostate cancer

CARDIAC
_____Heart Stent placed
_____CABG (Coronary Bypass)
_____Abdominal Aneurysm repair
_____Fem Pop Bypass (Leg Arteries)
_____Heart Valve replacement

OTHER
_____Thyroidectomy (Thyroid Surgery)
_____Glaucoma Surgery
_____Cataract Surgery

REVIEW OF SYSTEMS

*Please check any symptom or disease diagnosed during the **last 2 months** (Items left blank indicate a negative response)*

GENERAL
_____Loss of Appetite/Anorexia
_____Fatigue
_____Fever
_____Night Sweats
_____Weight gain in the last 3 months
Amount_____
_____Weight loss in the last 3 months
Amount_____
_____Are you under any stress?

SKIN
_____Purities/Itching
_____Skin Rash

ENT
_____Headache
_____Eye Pain
_____Eye Redness
_____Visual Loss
_____Nasal inflammation
_____Nose bleed(s)
_____Bleeding gums
_____Hoarseness
_____Oral Ulcers
_____Voice Changes

HEMATOLOGY
_____Enlarged Lymph Nodes
_____Prolonged Bleeding

GENITOURINARY
_____Blood in urine
_____Painful urination
_____Frequent urination
_____Urgency with urination
_____Do you have an implanted
bladder stimulator?

RESPIRATORY
_____Cough
_____Shortness of Breath
_____Wheezing

CARDIOVASCULAR
_____Chest Pain
_____Claudication's
_____Edema/Swelling
_____Difficulty breathing while laying down
_____Palpitations
_____Sleep Apnea
_____Shortness of Breath
_____Congestive Heart Failure
_____Myocardial Infarction
_____Valve Replacement

_____Do you have a Pacemaker?

_____Do you have an implanted defibrillator?

ENDOCRINE
_____Extreme thirst
_____Frequent Urination

NEUROLOGICAL
_____Difficulty Speaking
_____Focal Neurological Symptoms
_____Syncope
_____Incontinence Urine
_____Incontinence Stool
_____Seizure

PSYCHIATRIC
_____Feel scared or anxious
_____Depression
_____Feel like crying for no reason
_____Insomnia/Trouble Sleeping

GASTROINTESTINAL
_____Frequent constipation
_____Pain with bowel movement
_____Pale, greasy, oily or rancid stools
_____Mucus in or on your stool
_____Frequent diarrhea
_____Black or sticky stools
_____Blood in or on your stools
_____Vomit frequently
_____Vomit blood or "coffee grounds"
_____Bloating, belching or excessive gas
_____Difficult or painful swallowing
_____Frequent heartburn or indigestion
_____Frequent stomach pain
_____Recent changes in your bowel
movement
_____Jaundice (yellow eyes)

IMMUNIZATIONS

Please indicate if you have had the following immunizations:

Influenza (yearly) **Date:**_____

Pneumonia Vaccine **Date:**_____

Zostavax **Date:**_____

Hepatitis A **Date:**_____

Hepatitis B Series **Date:**_____

PATIENT MEDICATION LIST

Name:_____ Date: _____

Medication List should include all OTC and PRN medications.

Medication Name	Strength	# of times taken daily	Reason	Date