



CENTER FOR DIGESTIVE HEALTH

Phone: (248) 844-9710

Fax: (586) 726-8527

Website: www.troygastro.com

Sante D. Bologna, MD, FACP

John R. Weber, MD

Richard T. Wille, MD

Partha S. Nandi, MD, FACP

M. Emin Donat, MD FRCPC

Leonard G. Quallich III, MD

Anezi E. Bakken, MD, MS

Kerri A. Bewick, DO

Amir Abadir, MD, FRCPC

Dear Patient,

Welcome to our practice. Attached are forms which will provide us with your detailed information for your appointment. Thank you in advance for your cooperation in form completion. We look forward to providing you with quality care.

To ensure that our doctor will have your most recent medical information to treat you, please complete the enclosed Medical Records Release form. Enter your current Primary Care Physician or Gastroenterologist's information in the area titled "Persons Authorized to Use or Disclose Information".

Sign, date, and return the form(s) to our office prior to your scheduled visit. It is important that we receive this document as soon as possible in order to request your records be sent *prior to your appointment*. The Medical Records Release form can be mailed to the address on the form or it can be faxed to our office at (248) 844-9711. This process can take 2 days to 2 weeks depending on the timely response of all parties involved.

If there is not enough time to mail the Medical Records Release back to our office, simply bring it with you to your first appointment along with all other enclosed documents and your physician will request your records as needed.

Sincerely,

The Physicians and Staff at Center for Digestive Health



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Authorization of Disclosure of Protected Health Information by Another Covered Entity for Use by Center for Digestive Health

Information to be obtained under this authorization includes:

Medical records: Any procedure reports & pathology reports. Also include: office notes, labs, and discharge summary (if patient was hospitalized) within the last year.

Purposes of Disclosure

Information listed above will be disclosed for the following purposes: Continuity of care and Medical history

Persons Authorized to Disclose Information to our Physicians:

Name of Physician/Practice: _____

Address: _____ Phone: _____

_____ Fax: _____

Persons Authorized to Receive Disclosed Information:

Center for Digestive Health PC

1701 E South Blvd., Suite 300

Rochester Hills, MI 48307

(248) 844-9710 phone

(248) 844-9711 fax

Expiration Date of Authorization

This authorization is effective through 1 year unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to Center for Digestive Health. You should contact the practice manager to terminate this authorization.

Potential for Re-disclosure

Information that is disclosed under this authorization may be re-disclosed. The privacy of this information should be protected under the federal privacy regulations at the receiving entity.

Rights of the Individual

- You may inspect or request a copy of information that is used or disclosed under this authorization.
- You may refuse to sign this authorization.

Name of Patient (Print or Type)

Date of birth

Signature of Patient

Date signed



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Date of Appointment: _____

PATIENT INFORMATION

Please complete the following form and bring it with you on the day of your scheduled appointment.

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone # _____ Alt. Phone # _____ Alt. Phone # _____

Home Cell Work Other: _____ Home Cell Work Other: _____ Home Cell Work Other: _____

Birthdate: _____ Sex: Male Female **EMAIL** address: _____

Social Security #: _____ Marital Status: Single Married Divorced

Race: Caucasian African Amer. American Indian/Alaska Native Chinese, Japanese, Korean Filipino
 Multiracial Pacific Islander Other _____

Ethnicity: Hispanic/Latino Non-Hispanic/Non-Latino Other _____

Language: English Arabic Japanese/Chinese/Vietnamese Korean Polish Spanish Hindi
 German French Greek Mandarin Romanian Other _____

PATIENT EMPLOYMENT

Employment Status: Employed Retired Other

Employer: _____ Phone#: _____

Guarantor: _____ (if applicable)

Address: _____ City, State, Zip: _____

SPOUSE EMPLOYMENT

Employment Status: Employed Retired Other

Employer: _____ Phone#: _____

Social Security #: _____ Birthdate: _____

Attention Patients:

As a courtesy to our patients we will bill all charges to your insurance company. If payment is not received by your insurance company all charges will be your responsibility. Deductible, co-insurance and co-payments are part of your out of pocket responsibility as determined by your insurance and the contract you hold with them. It is also the patient's responsibility to check with their insurance to determine if a service is a covered benefit and what the insurance will cover towards a particular service.

If needed please contact our billing department to make payment arrangements and with any questions.

Date of Appointment: _____

MEDICAL INFORMATION

MEDICATIONS: Please list all current prescriptions and over the counter medications Check box if you have multiple medications and attach list

MEDICATION NAME	DOSE	FREQUENCY

ALLERGIES: Check box if you have multiple medication allergies and attach list
Drug Allergies _____

Check if allergic to:
 dairy iodine/shellfish/ IVP dye
 seasonal/ environmental
 other _____

MEDICAL HISTORY: Please check to indicate if you have any history of the following disorders

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Kidney Failure/Dialysis |
| <input type="checkbox"/> Pneumonia/ Bronchitis | <input type="checkbox"/> Hepatitis/ HIV | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizure |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Irregular Pulse | <input type="checkbox"/> Stroke <input type="checkbox"/> Colon Polyps |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Crohns | <input type="checkbox"/> Pacemaker/Defibrillator | <input type="checkbox"/> Glaucoma <input type="checkbox"/> Learning Disabilities |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Thyroid <input type="checkbox"/> Physical Limitations |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> IBS | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Hypoglycemia |
| | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Heart Problems: _____ | <input type="checkbox"/> Cancer: _____ |

Please list any other major illness: _____

SURGICAL HISTORY: Please check to indicate if you have any history of the following operations

- | | | | | | |
|------------------------------------|---|--|--|--|----------------------------------|
| <input type="checkbox"/> Colostomy | <input type="checkbox"/> Ileostomy | <input type="checkbox"/> Gastric Bypass/ Banding | <input type="checkbox"/> Joint replacement | <input type="checkbox"/> Metal implant | <input type="checkbox"/> IV Port |
| <input type="checkbox"/> Filters | <input type="checkbox"/> Stents (biliary cardiac, colon) | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Defibrillator | | |

Please list all major operations: _____

Have you ever had? Colonoscopy EGD Upper GI Barium Enema Ultrasound Abdominal CT/ MRI
If yes, where? _____

SOCIAL: Please indicate your consumption of the following as they are important to GI disorders

	DO YOU CONSUME?	HOW OFTEN?	AMOUNT
Alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Nicotine	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Caffeine	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Recreational Drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No (Marijuana, cocaine, etc.)	_____	_____
Domestic Violence	<input type="checkbox"/> Yes <input type="checkbox"/> No		

FAMILY HISTORY: Please complete the following information for your blood relatives:

	Father	Mother	Brother(s)	Sister(s)	Other:
Deceased	<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"/>
Cancer History:					
Colon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Esophageal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pancreatic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uterine/Breast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify)	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/>
Digestive History:					
Crohns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reflux	<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"/>
Colon Polyps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (Specify)	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/>
Cardiac History:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient Signature: _____ Date: _____

Full Name LFM Patient ID

Patient Health History

Reason for visit: _____

Describe your symptoms: _____

Please indicate yes or no if you have any of the symptoms listed below. Do you now, or do you have a history of:

GASTROINTESTINAL

- Poor appetite Yes No
- Difficulty in swallowing Yes No
- Heartburn Yes No
- Nausea or vomiting Yes No
- Bloating Yes No
- Belching Yes No
- Regurgitation Yes No
- Constipation Yes No
- Diarhea Yes No
- Abdominal pain Yes No
- Changes in bowel habits Yes No
- Rectal bleeding Yes No
- Jaundice Yes No
- Ulcer Yes No
- Black, tarry stools Yes No

CARDIOVASCULAR

- Shortness of breath Yes No
- Swelling of ankles/feet Yes No
- Heart murmur Yes No
- Irregular pulse Yes No

ENDOCRINE

- Heat or cold intolerance Yes No
- Excessive thirst/urination Yes No

HEMATOLOGICAL

- Bleeding/bruising Yes No
- Swollen glands Yes No

RESPIRATORY

- Chronic cough Yes No
- Spitting up blood Yes No
- Wheezing Yes No

MUSCULOSKELETAL

- Joint/muscle pain Yes No
- Muscle pain Yes No
- Arm/leg weak/numbness Yes No
- Back/neck pain Yes No

CONSTITUTIONAL

- Recent weight change Yes No
- Fever Yes No
- Fatigue Yes No
- Night Sweats Yes No
- Infections/Injuries Yes No

SKIN

- Rash Yes No
- Itching Yes No

PSYCHIATRIC

- Memory loss or confusion Yes No

GENITOURINARY

- Burning with urination Yes No
- Blood in urine Yes No
- Frequent/urgent urination Yes No
- Incontinence Yes No

EYES

- Blurred vision Yes No
- Infections/Injuries Yes No
- Double/blurred vision Yes No

NEUROLOGICAL

- Headaches Yes No
- Numbness Yes No
- Disorientation Yes No
- Weakness Yes No

EARS/NOSE/MOUTH

- Hearing loss Yes No
- ringing in ears Yes No
- Mouth sores Yes No
- Sore throat Yes No

To expedite prescription prior authorizations indicate if you have ever taken any of the following medications:

Medication	Yes	Dates (if known)	Medication	Yes	Dates (if known)	Medication	Yes	Dates (if known)
Aciphex			Fibersure			Pantoprazole		
Amitiza			Glycolax			Pepcid		
Benefiber			Kapidex			Prevacid		
Citrucel			Kristalose			Prilosec		
Correctol			Lactulose			Protonix		
Dexilant			Lansoprazole			Reglan		
Dulcolax			Metamucil			Tagamet		
Dulcolax Balance			Nexium			Zantac		
Exlax			Omeprazole			Zegerid		
Fibercon			Pantoprazole			Other		

Patient Signature: _____ Date: _____