CENTER FOR DIGESTIVE HEALTH

Phone: (248) 844-9710
Fax: (248) 844-9711
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

CENTER FOR DIGESTIVE HEALTH

Phone: (248) 844-9710
Fax: (248) 844-9711
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

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.

Treatment, Payment or Operations
Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is provided by the Privacy Rule.

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 (please print) Date of Birth

____ ____
Signature of Patient/Patient Representative Date Signed

____
Relationship of Patient Representative to Patient

CENTER FOR DIGESTIVE HEALTH

Phone: (248) 844-9710
Fax: (248) 844-9711
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

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

☐ Emphysema
☐ Pneumonia/ Bronchitis
☐ Arthritis
☐ Depression
☐ Anemia
☐ Blood Transfusion
☐ Blood Disorder

☐ Liver Disease
☐ Hepatitis/ HIV
☐ Ulcer
☐ Crohns
☐ Pancreatitis
☐ IBS
☐ Ulcerative Colitis
☐ Weight Loss

☐ High Cholesterol
☐ High Blood Pressure
☐ Irregular Pulse
☐ Pacemaker/Defibrillator
☐ Congestive Heart Failure
☐ Heart Murmur
☐ Chest Pain
☐ Heart Problems: ____________________

☐ Kidney Failure/Dialysis
☐ Seizure
☐ Stroke
☐ Glaucoma
☐ Thyroid
☐ Diabetes
☐ Hypoglycemia
☐ Cancer:_____________________

☐ Colon Polyps
☐ Learning Disabilities
☐ Physical Limitations

Please list any other major illness: ____

____

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

☐ Colostomy ☐ Ileostomy ☐ Gastric Bypass/ Banding ☐ Joint replacement ☐ Metal implant ☐ IV Port

☐ Filters ☐ Stents (biliary cardiac, colon) ☐ Pacemaker ☐ 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	☐ Yes ☐ No	______________________	____________________
Nicotine	☐ Yes ☐ No	______________________	____________________
Caffeine	☐ Yes ☐ No	______________________	____________________
Recreational Drugs	☐ Yes ☐ No (Marijuana, cocaine, etc.)	______________________	____________________
Domestic Violence	☐ Yes ☐ No		

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

	Father	Mother	Brother(s)	Sister(s)	Other:
Deceased	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Cancer History:					
Colon	☐	☐	☐	☐	☐
Esophageal	☐	☐	☐	☐	☐
Pancreatic	☐	☐	☐	☐	☐
Uterine/Breast	☐	☐	☐	☐	☐
Other (specify)	☐_______________	☐________________	☐________________	☐_______________	☐
Digestive History:					
Crohns	☐	☐	☐	☐	☐
Reflux	☐	☐	☐	☐	☐
Ulcerative Colitis	☐	☐	☐	☐	☐
Colon Polyps	☐	☐	☐	☐	☐
Other (Specify)	☐_______________	☐________________	☐________________	☐ _______________	☐
Cardiac History:	☐_______________	☐________________	☐________________	☐ _______________	☐

Patient Signature:____ Date:___________________

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
Diarrhea ☐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

CONSTITUTIONAL

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

EYES

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

EARS/NOSE/MOUTH

Hearing loss ☐Yes ☐No
Ringing in ears ☐Yes ☐No
Mouth sores ☐Yes ☐No
Sore throat ☐Yes ☐No

CARDIOVASCULAR

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

RESPIRATORY

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

SKIN

Rash ☐Yes ☐No
Itching ☐Yes ☐No

GENITOURINARY

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

NEUROLOGICAL

Headaches ☐Yes ☐No
Numbness ☐Yes ☐No
Disorientation ☐Yes ☐No
Weakness ☐Yes ☐No

ENDOCRINE

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

HEMATOLOGICAL

Bleeding/ /bruising ☐Yes ☐No
Swollen glands ☐Yes ☐No

MUSCULOSKELETAL

Joint/muscle pain ☐Yes ☐No
Muscle pain ☐Yes ☐No
Arm/ leg weal/ numbness ☐Yes ☐No
Back/neck pain ☐Yes ☐No

PSYCHIATRIC

Memory loss or confusion ☐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:________________