TDDC

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Office Phone: 281-764-9500

Office Fax: 281-764-9501

Website: www.tddctx.com

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- **To better assist you with your call needs, below is a list of our phone system options.**

Option 1- Office Hours, Fax Number, and Office Locations

Option 2- Appointments and General Questions

Option 3- Billing Questions.

If your call is routed to our answering service during business hours, please leave a message. Our goal is to return your call within 1 to 2 hours. Multiple messages will delay response time. Thank you!

- **NO-SHOW & CANCELLATION POLICY:**

Office Visits: We would appreciate that you notify our office 1 business day prior to visit to cancel or reschedule. Cancellations not reported within this time frame are subject to a $50.00 fee per occurrence.

Procedures Visits: We would appreciate that you notify our office 3 business day prior to visit to cancel or reschedule. Cancellations not reported within this time frame are subject to a $100.00 fee per occurrence.

Thank you for choosing Texas Digestive Disease Consultants for your health care needs.

Attached is our new patient packet. As a reminder, there is an electronic version of these forms available for you to complete at the time of your appointment. However, if you're more comfortable with completing the forms by hand, please do so and bring the documents with you to your appointment. **Please DO NOT return your forms via email**.

In order to expedite your check in process, please register on our NEW patient portal prior to your appointment. You should have received an invitation to the portal at the time you scheduled your appointment. If you did not receive it, please call our office and we will be happy to resend the invite. Please complete the Health Summary section and click "SEND". This allows us to update your information instantly and save you time at check in!

If you did not complete this online Health Summary Section prior to your visit, you are required to check in 20 minutes prior to your scheduled appointment; otherwise, you only need to check in 10-minutes prior to your appointment.

What to bring:

1. Patient Interview Forms, **IF** you did not register on the patient portal
2. Insurance Card
3. Driver's License or State Issued ID
   - Patients under the age of 18 must be accompanied by their parent or guardian.
4. Medical Records, if applicable
5. Insurance Authorized Referral from your Primary Care, if applicable
6. Specialist Co-payment, which will be collected upon check-in. We accept Cash, Checks, Visa, MasterCard, and Discover.

Our goal is to verify your insurance eligibility and benefits 1 - 2 days prior to your appointment. We will make every effort to contact you prior to your appointment if we need additional information regarding your insurance coverage. However, it is important that you too verify our provider's participation with your insurance network and check if an authorized referral from your insurance carrier is required.

Please note, if you have an EPO or HMO plan, an authorized referral from your insurance carrier **WILL** be required. We would appreciate your assistance in obtaining one from your PCP for insurance carriers do not allow us to initiate these authorization requests. When contacting your PCP, please inform them to obtain the authorization for evaluation and treatment.

Please contact our office at 281-764-9500 should you need to cancel or reschedule your appointment.

We appreciate the opportunity to participate in your care.

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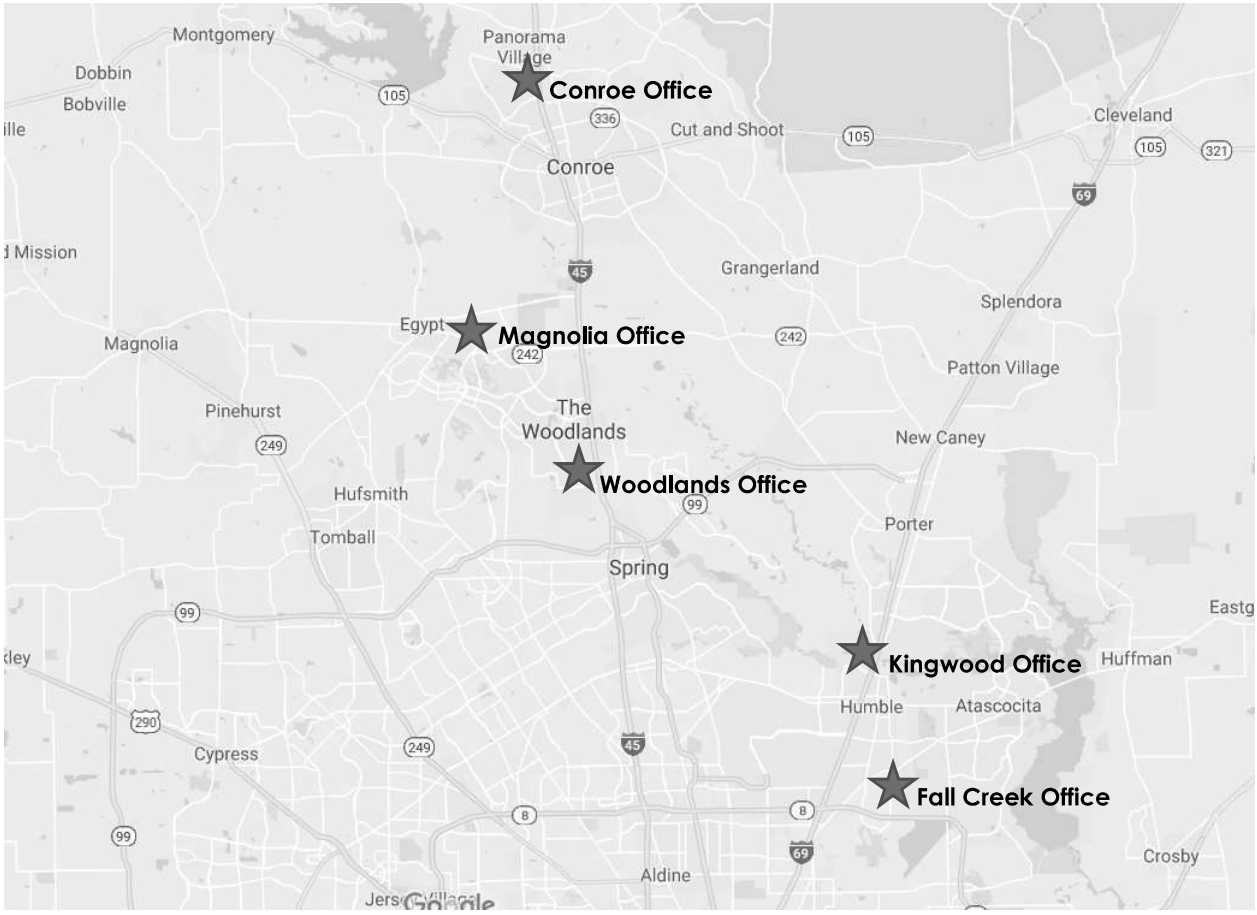
We have 5 locations to better serve you



**Office Hours: Monday through Thursday 8:30am to 5:00pm. Friday 8:30am to 3:00pm.

Main Offices:

Woodlands: 26103 Interstate 45, Suite 100 Spring, TX 77380

Kingwood: 310 Kingwood Executive Drive, Suite B Kingwood, TX 77339

Satellite Offices:

Humble: 9240 N Sam Houston Parkway E, Suite 202 Humble, TX 77396

Conroe: 4015 Interstate 45, Suite 210-02 Conroe, TX 77304

Magnolia: 10020 Research Forest Drive, Suite A Magnolia, TX 77354

**Our physicians and staff have specific days and hours in which they are in our satellite offices.

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Patient Interview Form

Patient Information

First Name: _____ Last Name: _____

MRN: _____ Date Of Birth: _____

Age: _____

Email

Please check one as your preferred email for communications

☐ Personal: _____ ☐ Work: _____

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient declines to specify ☐ Prohibited by state law ☐ Unknown

Race

Select one or more

☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander

☐ Other Race ☐ Unknown ☐ Patient declines to specify ☐ Prohibited by state law

Preferred Language

☐ English ☐ Korean ☐ Spanish; Castilian ☐ Patient declines to specify

Contact Preference

☐ Telephone call ☐ Portal ☐ Patient declines to specify Other: _____

Allergies

☐ Patient has no known allergies ☐ Patient has no known drug allergies

Food ☐ Eggs ☐ Nuts ☐ Shellfish

Medication

☐ Aspirin ☐ Cipro ☐ Codeine ☐ Demerol ☐ Fentanyl

☐ Flagyl ☐ Iodine ☐ IV dye ☐ Levaquin ☐ Morphine

☐ Penicillins ☐ Versed ☐ Sulfa ☐ Latex Other: _____

☐ Manifestations/Reactions:

Immunizations

☐ None

☐ Hepatitis B vaccine When: _____

☐ Hepatitis A vaccine When: _____

☐ Influenza vaccine When: _____

☐ Influenza, vaccine rejected When: _____

☐ Pneumovax vaccine When: _____

☐ Tetanus vaccine When: _____

☐ Varicella/VZV vaccine When: _____

☐ Moderna COVID-19 When: _____

☐ Pfizer COVID-19 When: _____

☐ Janssen COVID-19 When: _____

Current Medications

☐ None

Name	Dose	How taken?

Pharmacy

Name	Address	Phone

Past Medical History

☐ None

Cancers:

☐ Colon ☐ Esophageal ☐ Liver ☐ Small intestine
☐ Stomach ☐ Kidney ☐ Pancreas ☐ Bladder
☐ Lymphoma ☐ Lung ☐ Skin ☐ Prostate
☐ Breast ☐ Cervical ☐ Ovarian ☐ Uterine

Other: _____

Liver:

☐ Fatty liver ☐ Hepatitis A, active ☐ Hepatitis B, active ☐ Hepatitis C, active
☐ Hepatitis, autoimmune

Other: _____

Digestive:

☐ Acid reflux ☐ Barrett's esophagus ☐ Celiac sprue ☐ Cirrhosis of liver
☐ Colon polyps ☐ Crohn's disease ☐ Diverticulitis (infected) ☐ Diverticulosis
☐ H. pylori ☐ Irritable bowel syndrome ☐ Pancreatitis ☐ Ulcer
☐ Ulcerative colitis

Other: _____

Miscellaneous:

☐ Anxiety/Panic attacks ☐ Anemia ☐ Arthritis ☐ Asthma
☐ Atrial fibrillation ☐ Congestive heart failure ☐ Coronary artery disease ☐ Depression
☐ Diabetes ☐ Emphysema ☐ Endometriosis ☐ Fibromyalgia
☐ Glaucoma ☐ Heart attack ☐ High blood pressure ☐ High cholesterol
☐ HIV ☐ Kidney disease ☐ Lupus ☐ Osteopenia
☐ Osteoporosis ☐ Seizure disorder ☐ Sleep apnea ☐ Stroke/TIA
☐ Thyroid, overactive ☐ Thyroid, underactive

Other: _____

Supplements -if using the patient portal, please enter through the medication section instead.

☐ Please list vitamins: _____

☐ Please list herbal supplements: _____

☐ Please list dietary supplements: _____

Previous Gastroenterology Procedures

- [ ] None
- [ ] Colonoscopy
- [ ] EGD/Upper endoscopy
- [ ] ERCP
- [ ] Endoscopic ultrasound/EUS
- [ ] Small bowel capsule
- [ ] Liver biopsy

Other: _____

Surgical Procedures

- [ ] None
- [ ] Appendectomy
- [ ] C-Section
- [ ] Cataract surgery
- [ ] Colon resection
- [ ] Coronary artery bypass
- [ ] Coronary/Stent
- [ ] Defibrillator
- [ ] Gallbladder removed
- [ ] Gastric bypass
- [ ] Heart valve replacement/repair
- [ ] Hemorrhoidectomy
- [ ] Hiatal hernia surgery (for reflux)
- [ ] Uterus and ovaries removed
- [ ] Uterus removed
- [ ] Ovaries removed
- [ ] Inguinal hernia surgery (groin)
- [ ] Joint surgery / replacement
- [ ] Lap band
- [ ] Liver transplant
- [ ] Mastectomy
- [ ] Pacemaker
- [ ] Prostatectomy
- [ ] Tonsillectomy
- [ ] Tubal ligation
- [ ] Ulcer surgery
- [ ] Umbilical hernia surgery (belly-button)

Other: _____

Social History

Occupation: _____

Marital Status

- [ ] Single
- [ ] Married
- [ ] Divorced
- [ ] Separated
- [ ] Widowed
- [ ] Other

Alcohol

- [ ] None
- [ ] Less than 7 drinks per week
- [ ] More than 7 drinks per week
- [ ] I quit using alcohol

Smoking Status

- [ ] Current every day smoker
- [ ] Current some day smoker
- [ ] Former smoker
- [ ] Never smoker
- [ ] Smoker, current status unknown
- [ ] Light tobacco smoker
- [ ] Heavy tobacco smoker
- [ ] Unknown if ever smoked
- [ ] Cigar
- [ ] Chewing Tobacco

Drug Use

- [ ] None
- [ ] I have used recreational drugs in the past
- [ ] I am currently using recreational drugs
- [ ] I have been treated for substance abuse

Family Medical History

No knowledge of family history

No family history of Colon cancer Polyps

	Mother	Father	Sister	Brother	Daughter	Son	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Maternal Aunt	Maternal Uncle	Paternal Aunt	Paternal Uncle	Other
Diagnoses															
Colon Cancer	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Colon polyps	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Crohn's disease/Ulcerative colitis	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Liver disease	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Kidney cancer	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Uterine cancer	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Stomach cancer	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Bladder cancer	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Pancreatic cancer	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Ovarian cancer	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Consent to Import Medication History

I consent to obtaining a history of my medications purchased at pharmacies.

I consent to obtaining a history of my medications purchased at pharmacies.

Yes No

Reminder Preference

I would like to receive preventive care and follow up care reminders.

I would like to receive preventive care and follow up care reminders.

Yes No

Reviewed with

Patient Parent Guardian Not Present

Signature

Signature Date