Digestive Disorders Associates

Gastroenterology

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www.dda.net

Dear Patient:

Welcome to Digestive Disorders Associates. We understand your health is a top priority, and we appreciate the trust you showed by choosing DDA to help you.

Your appointment has been scheduled for _____at _____. Please arrive at least 15 minutes early to allow for a seamless check in.

Functional gastrointestinal (GI) and motility disorders have a variety of symptoms and activities, so we will rely on a lot of information from you before and during your first appointment. To ensure we have the necessary information, we have compiled this new patient packet which includes:

- ☐ Patient Interview Form (Medical History)
- ☐ Review of Symptoms
- ☐ Office Policies & Procedures Agreement
- ☐ Financial Policy
- ☐ Release of Medical Records Authorization
- ☐ Credit Card on File Authorization

Please complete this packet and bring it to your appointment, along with your:

- ☐ Insurance Card
- ☐ Picture ID
- ☐ Referral from your physician (if required)
- ☐ Pertinent Medical Records - Prior Tests and Procedures related to your visit
- ☐ Co-Pay listed for specialist

Your co-payment, if required, is due at the time of service (details of our policy are included in your packet.) We accept cash, checks, and credit cards for payment. Finally, we strongly encourage you to visit our website www.dda.net to learn more about your doctor, your condition, and other relevant information. You can also sign up for our patient portal, which will allow you to contact your physician directly, request medication refills and book appointments. If you have any questions or concerns, please feel free to call our office, 410-224-4887. If you need to cancel your appointment, please contact the office at least 24 hours in advance at 410-224-4887 to avoid a $50 missed appointment fee.

We look forward to meeting you.

Sincerely,

Digestive Disorders Associates

DIRECTIONS TO THE OFFICES OF DIGESTIVE DISORDERS ASSOCIATES

ANNAPOLIS OFFICE

RIDGELY OAKS PROFESSIONAL CENTER

621 RIDGELY AVENUE, SUITE 201

ANNAPOLIS, MD 21401

FROM BALTIMORE:

- I-695 SOUTH, EXIT I-97 SOUTH
- I-97 TO ROUTE 50 EAST
- THEN FOLLOW ROUTE 50 EAST DIRECTIONS LISTED BELOW

FROM ROUTE 50 EAST:

- FROM ROUTE 50E TAKE EXIT 24(ROWE BLVD/BESTGATE RD)
- TURN LEFT ONTO BESTGATE RD
- AT FIRST LIGHT, TURN RIGHT ONTO N. BESTGATE RD
- GO TO STOP SIGN AND TURN RIGHT ONTO RIDGELY AVE
- RIDGELY OAKS IS APPROXIMATLEY ¼ MILE ON THE RIGHT

FROM ROUTE 50 WEST:

- FROM ROUTE 50W TAKE EXIT 24B (BESTGATE RD)
- AT FIRST LIGHT, TURN RIGHT ONTO N BESTGATE RD
- GO TO STOP SIGN & TURN RIGHT ONTO RIDGELY AVE
- RIDGELY OAKS IS APPROXIMATELY ¼ MILE ON THE RIGHT

FROM DOWNTOWN ANNAPOLIS:

- FOLLOW ROWE BLVD TO THE 2ND LIGHT
- TURN RIGHT ONTO MELVIN AVE
- GO TO STOP LIGHT & TURN LEFT ONTO RIDGELY AVE
- RIDGELY OAKS IS APPROXIMATELY 1 MILE ON THE LEFT

GAMBRILLS OFFICE

AAMC HEALTH SERVICES BUILDING

2401 BRANDERMILLS BLVD, SUITE 330

GAMBRILLS, MD 21054

FROM ROUTE 50EAST:

- TAKE US 301/MD 3 **(EXIT 13)** NORTH TOWARDS CROFTON
- TRAVEL APPROXIMATELY 7 MILES THEN TAKE A LEFT TURN ON TO CHAPEL LAKES RD.
- THE AAMC HEALTH SERVICES IS IMMEDIATELY ON YOUR RIGHT

FROM ROUTE 50 WEST:

- TAKE US 301/MD 3 **(EXIT 13)** NORTH TOWARDS CROFTON
- TRAVEL APPROXIMATELY 7 MILES THEN TAKE A LEFT TURN ON TO CHAPEL LAKES RD.
- THE AAMC HEALTH SERVICES IS IMMEDIATELY ON YOUR RIGHT

FROM BALTIMORE

- TAKE EXIT FOR 695 –EAST TOWARDS GLEN BURNIE

TAKE EXIT 4 FOR 97 SOUTH TOWARDS ANNAPOLIS

- TRAVEL 9.8 MILES ON 97 SOUTH THEN MERGE ONTO RT 3 SOUTH TOWARDS BOWIE
- TRAVEL ALMOST 4 MILES AND YOU WILL SEE THE AAMC HEALTH SERVICES BUILDING ON YOUR RIGHT

TURN RIGHT ON TO CHAPEL LAKE RD., THE BUILDING WILL BE IMMEDIATELY ON YOUR RIGHT

CHESTER OFFICE

ANNE ARUNDEL MEDICAL CENTER - KENT ISLAND FACILITY

1630 MAIN STREET, SUITE 213

CHESTER, MD 21619

FROM WESTERN SHORE/ROUTE 50 EAST:

- FROM ROUTE 50E CROSS THE BAY BRIDGE
- TAKE EXIT 39B (DOMINION RD)
- TURN RIGHT AT THE TRAFFIC LIGHT
- BARE RIGHT AND CROSS OVERPASS
- TAKE 1ST LEFT TO AAMC FACILITY
- ACROSS FROM THE FIRE STATION

FROM EASTERN SHORE/ROUTE 50 WEST:

- TAKE EXIT 39A (CASTLE MARINA RD)
- ENTER TRAFFIC CIRCLE
- BARE RIGHT AT THE CIRCLE ONTO MAIN ST
- MAKE FIRST RIGHT INTO AAMC FACILITY

OFFICE POLICY AND PROCEDURES

1. _____**REFERRALS- Patients must present a valid referral (if required) at the time of service or the visit must be paid in full or rescheduled. We do NOT contact primary care physicians for referrals. Please make sure your referral is dated, the referring physician or facility name is correct, the place of service is marked as office, and that the referral has not expired. If you are unsure of the expiration date, PLEASE verify with primary care physician and have them mark this. (It is the PATIENT'S RESPONSIBILITY to obtain a copy of the referral for their visit.)**

2. _____**CANCELLATIONS-** Our office requires a 24-hour notice for cancellation. If an appointment is not cancelled, the patient is charged a no-show fee of **$50.00.** Failure to cancel an appointment for a procedure with the MDTEC facility within 48-hours will result in a fee in the amount of **$200.00.** If you believe you were charged this no-show fee in error, we allow 30 days to dispute this charge. This amount will be due prior to the patient's next visit.

3. _____**MEDICAL RECORDS-** Medical Records request require 5 to 10 business days to complete and they are processed by an off-site service. There is a fee for this processing mandated by Maryland State Law. This fee is $22.00 plus an additional $0.73 per page for **physician transfers**. For **patient personal use** there is a fee of $0.73 per page ONLY. **Pre-payment maybe required.**

4. _____**CO-PAYMENTS-** Co-payments **must** be paid at the time of service. This is required in the terms of your contract with your insurance company. There is a $5.00 service fee for non-payment of your copay. Any amounts that are applied to the patient's deductible are due and payable prior to the patient's next visit or within 30 days after we receive notification from your insurance company, whichever comes first. If you are unable to make these payments, arrangements may be made with our billing department prior to your next visit.

5. _____**INSURANCE-** Patients must present appropriate insurance information at the time of service or the visit will be rescheduled. If your card does not have the appropriate information listed, you will be responsible for your visit.

6. _____**PRESCRIPTIONS-** Prescription refills and prior authorizations require 72 hours notice to be filled. Detailed information must be left in order for this process to be completed and it is preferred that patients have their pharmacies fax over refill request on their behalf.

7. _____**DEDUCTIBLE** – If your deductible limit has not been reached at the time of your appointment, we will collect the full deductible amount. The exact amount will be determined by the type of appointment. New patients will pay $200 before they are seen by their physician; existing patients who have a follow up visit schedule, the amount collected will be $100. We accept payments using cash, personal check, credit and debit cards or by credit card on file.

8. _____**CREDIT CARD ON FILE** – Patients have the option of keeping a credit card on file. If there are any additional charges the patient is responsible for once the insurance claim has been adjudicated, including the physician, facility, anesthesia and pathology (lab) fees, we will use this credit card for those charges. It can also be used for any upfront deductible charges.

I authorize release of my medical records to my insurance company, if necessary, to process my claim. I understand that this authorization may be revoked by me, in writing, at any time.

I authorize Digestive Disorders Associates to obtain medical records relating to my care from previous providers of service.

_____ _____

Patient or Responsible Party Signature Date

_____ _____

Patients Name (Please Print) Responsible Party (Please Print)

Digestive Disorders Associates

FINANCIAL POLICY

Thank you for choosing Digestive Disorders Associates (DDA) as your Gastroenterology specialty healthcare provider. We are committed to providing you and your family with the best available medical care. To keep you informed of our current office and financial policies, we require you to read and sign this agreement. We will place a signed copy in your chart, and you may keep a copy for future reference.

Payments for all services will be due at the time services are rendered. In order to serve you better, we accept cash, check, Visa, MasterCard, Discover and American Express. As a courtesy to you, we will bill your insurance carrier, although you are ultimately responsible for the entire bill. We will be glad to bill a maximum of two (2) insurance companies. We cannot bill your insurance company unless you give us your correct insurance information and driver's license.

(PLEASE INITIAL THE FOLLOWING)

_____ 1. Your medical insurance is a contract between you and your insurance company. We are not a party to that contract, and your bill is ultimately your responsibility whether your insurance company pays or not. It is your responsibility to understand your insurance policy and to know if we are participating providers with your specific plan. We will not become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, and secondary insurance charges. As your medical provider, we will only supply facility information to facilitate claim processing.

_____ 2. All co-payments, insurance deductibles and fees for services not covered by your insurance policy are due at the time service is rendered. The co-pay cannot be waived, as it is a requirement placed on you by your insurance company.

_____ 3. All charges are your responsibility whether your insurance company pays or does not pay. If your insurance carrier does not remit payment in full within 60 days, the balance will be due in full by you. Any balance unpaid after 60 days from the date of services rendered will be subject to interest at the annual percentage rate of 18%. If payment is made directly to you for services billed by our center, you recognize an obligation to promptly remit payment to Digestive Disorders Associates.

_____4. If you are unable to keep your appointment, please notify our office at least 24 hours before your scheduled appointment. Missed appointments are subject to the following fee:

- Missed appointment: $50

_____5. Returned payments, and collection fees incurred by use of an outside collection agency are subject to the following fees:
Returned payments: $35 per transaction
Collection Agency Fee: 40% of total balance transferred to collections and any additional attorney fees and costs that apply to collections.

Digestive Disorders Associates

_____6. Medical records request require 5 to 10 business days to process. There is a fee for this processing mandated by Maryland State Law. This fee is $22.00 plus an additional $0.73 per page for physician transfer. For patient personal use there is a fee of $.073 per page ONLY. Pre-Payment is required and patient pickup is recommended.

_____**7**. Credit Card on File. Patients have the option of keeping a credit card on file. If there are any additional charges the patient is responsible for once the insurance claim has been adjudicated, including the physician, facility, anesthesia and pathology (lab) fees, we will use this credit card for those charges. It can also be used for any upfront deductible charges.

_____8. It is your responsibility to know if your insurance company requires you to have a referral and to bring the referral to your appointment. If you do not have your referral you will be required to re-schedule, or pay in full for your visit.

_____9. Self-pay patients are required to pay their visits in full at the time of service.

_____10. I acknowledge that I have received the following prior to being seen by a physician:

- HIPPA NOTICE
- Financial Policy Agreement
- Office Policies and Procedures Agreement
- Credit Card on File Authorization

_____11. I consent to DDA's use and disclosure of my protected health information for treatment, payment, and health care operations. I understand that I have the right to revoke this consent in writing, except where DDA has already made disclosure in trust, based on prior consent.

I UNDERSTAND THE ABOVE INFORMATION AND MY SIGNATURE BELOW ATTESTS TO MY CONSENT:

Printed Name of Patient: _____Date:_____

Patient Signature: _____Date:_____

OR

_____ _____ _____

Patient's Representative (Please Print) **Representative's Signature** **Date**

Revised 2/2016

Digestive Disorders Associates

PERMISSION TO DISCLOSE RELEVANT HEALTH INFORMATION TO INDIVIDUALS INVOLVED IN MY HEALTH CARE

☐ I GIVE PERMISSION for **Digestive Disorders Associates** to disclose relevant health information (my health status, treatment, and payment arrangements) to my family members and to the individual(s) I have listed below who are involved in my health care:

Name:_____ **Name:** _____

Relationship:_____ **Relationship:** _____

Name:_____ **Name:** _____

Relationship:_____ **Relationship:** _____

☐ I DO **NOT** GIVE PERMISSION for **Digestive Disorders Associates** to disclose relevant health information (my health status, treatment, and payment arrangements) to family members and other individuals involved in my health care.

Patient's Signature:_____ **Date:** _____

Patient's Printed Name: _____

* Patient is a minor (____years of age) *OR is unable to give permission because: _____

_____

Signature of Individual Signing on Behalf of Patient:_____**Date:** _____

Credit Card on File Authorization

Patient: _____ **Account #:** _____

AGREEMENT

Until further notice, I authorize Digestive Disorders Associates, Maryland Diagnostic & Therapeutic Endo Center, and Maryland Anesthesia Providers to charge the patient-responsible balances on my account to the following credit card:

Circle one: Visa Mastercard Discover A/E

Type: Credit HSA FSA

Card Number: _____

Exp. Date (mm/yy): _____

3 Digit Security Code: _____

I understand that once the insurance has paid their portion for my care, I will receive an Explanation of Benefits (EOB) from my insurance company. The insurance plan EOB will state any balance remaining to be paid by me. I agree that my credit card on file may be charged for the balance due at the time the copy of the EOB is received by the provider.

Signature: _____ Date: _____

Printed Name of Cardholder: _____

Date of Birth: _____ Last 4 digits of SSN: _____

NOTE: *Your credit card information is not kept on file in this office. It is kept securely offsite and this office does not have access to the full credit card number once it is entered into the system the first time.*

Last Updated 7/19/2016

Digestive Disorders Associates

Thank you for choosing Digestive Disorders Associates to participate in your health care. While our staff is preparing for your visit, please complete these few quick questions as to the reason for today's visit.

Name:_____

Reason for today's visit:_____

_____

Please check off the symptoms below that apply to your current problem.

Allergic/Immunologic	Yes	No
HIV Exposure		
Persistent Infections		
TB Exposure		

Cardiovascular	Yes	No
Chest Pain		
Palpitations		

Constitutional	Yes	No
Fever		
Loss of Appetite		
Weight Gain		
Weight Loss		

Eyes	Yes	No
Double Vision		
Sensitivity to Light		

Gastrointestinal	Yes	No
Difficulty Swallowing		
Heartburn		
Abdominal Pain		
Abdominal Swelling		
Change in Bowel Habits		
Constipation		
Diarrhea		
Gas		
Jaundice		
Nausea		
Rectal Bleeding		
Stomach Cramps		
Vomiting		
Hemorrhoids		

Hematologic/Lymphatic	Yes	No
Easy Bruising		
Prolonged Bleeding		

Skin	Yes	No
Rashes		

Musculoskeletal	Yes	No
Arthritis		
Muscle Weakness		

Psychiatric	Yes	No
Anxiety		
Depression		
Difficulty Sleeping		
Nervousness		

Respiratory	Yes	No
Cough		
Coughing up Blood		
Shortness of breath w exercise		

My local pharmacy is: _____

In order to insure that you maintain your medication regime on schedule, please be sure to request any refills that you may need before your next visit.

Medicare	**Yes**
	No
Appointment Type	**Consult**
	Follow-Up

Digestive Disorders Associates

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(410)224-1428 Fax

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:_____

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

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Sex

☐ Male ☐ Female ☐ Other

Preferred Language

☐ English ☐ Patient declines to specify

Contact Preference

☐ Home Telephone ☐ Cell Phone ☐ Patient Portal ☐ Patient declines to specify Other:_____

Allergies

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

☐ Soy ☐ Eggs ☐ Nuts / Peanuts ☐ Penicillins ☐ Demerol

☐ Valium ☐ Amoxicillin ☐ Cipro ☐ Augmentin ☐ Latex

☐ Versed ☐ Morphine ☐ Aspirin ☐ Sulfa (Sulfonamide Antibiotics) Other:_____

Current Medications

☐ None

Name	Dose	How taken?

Past or Present Medical Conditions

☐ None

General

- ☐ Open Skin Wounds or Rashes — When: ____ Other: ____
- ☐ Organ Transplant Recipient — When: ____
- ☐ Previous Organ Donor — When: ____
- ☐ Sexually Transmitted Diseases — When: ____

Cardiac & Vascular

- ☐ None (Cardiac or Vascular) — When: ____
- ☐ Implanted Pacemaker — When: ____
- ☐ Implanted Defibrillator — When: ____
- ☐ Congestive Heart Failure / Enlarged Heart — When: ____
- ☐ Atrial Fibrillation — When: ____
- ☐ Heart Murmur — When: ____
- ☐ Chest / Heart Pain — When: ____
- ☐ Mitral Valve Prolapse — When: ____
- ☐ Heart Attack — When: ____
- ☐ Hypertension / High Blood Pressure — When: ____ Other: ____
- ☐ Vascular Disease — When: ____
- ☐ Deep vein thrombosis — When: ____
- ☐ Venous Access Device — When: ____

Pulmonary

- ☐ None (Pulmonary) — When: ____
- ☐ Use Oxygen at Home — When: ____
- ☐ COPD — When: ____
- ☐ Emphysema — When: ____ Other: ____
- ☐ Asthma — When: ____
- ☐ Tuberculosis — When: ____
- ☐ Sleep apnea — When: ____

Neurological

- ☐ None (Neurologic) — When: ____ Other: ____
- ☐ CVA / Stroke — When: ____
- ☐ Seizures — When: ____
- ☐ Altered Mental Status — When: ____

Endocrine

- ☐ None (Endocrine) — When: ____
- ☐ Diabetic-Managed with Insulin — When: ____
- ☐ Diabetic-Managed with Oral Medication — When: ____
- ☐ Use Insulin Pump — When: ____ Other: ____
- ☐ Graves Disorder — When: ____
- ☐ Hyperthyroidism — When: ____
- ☐ Hypothyroidism — When: ____

Hematologic / Cancer / Infections

- ☐ None (Hematologic / Cancer / Infection) — When: ____
- ☐ Radiation to the Head, Neck, Throat or Chest — When: ____
- ☐ Taking Blood Thinner Medication / Anticoagulant — When: ____
- ☐ Anemia — When: ____
- ☐ Bleeding Disorder — When: ____
- ☐ Blood Transfusion History — When: ____
- ☐ Diagnosed with Cancer — When: ____
- ☐ Diagnosed with Colon Cancer — When: ____
- ☐ Lung cancer — When: ____
- ☐ Liver Cancer — When: ____
- ☐ Esophageal Cancer — When: ____
- ☐ Chronic Infectious Disease — When: ____

	☐ HIV When:_____	☐ Prostate Cancer When:_____	☐ Melanoma / Skin Cancer When:_____	☐ Basal Cell Carcinoma When:_____
Gastrointestinal	☐ None (Gastrointestinal) When:_____	☐ Liver Disease When:_____	☐ Hepatitis A When:_____	☐ Hepatitis B When:_____
	☐ Hepatitis C When:_____	☐ Other Hepatitis When:_____	☐ Barretts Esophagus When:_____	☐ Acid Reflux / GERD When:_____
	☐ Chronic Diarrhea When:_____	☐ Ulcer When:_____	☐ Hiatal Hernia When:_____	☐ Colostomy / Ileostomy / PEG Tube When:_____
	☐ Ulcerative Colitis When:_____	☐ Crohn's Disease When:_____	☐ Irritable Bowel Syndrome When:_____	☐ Colon Polyps When:_____
	☐ Stomach Polyps When:_____	☐ Cirrhosis When:_____	☐ Diverticulitis When:_____	☐ Gallstones When:_____
	☐ Pancreatitis When:_____	Other:_____		
Genitourinary	☐ None (Genitourinary) When:_____	☐ Kidney Failure When:_____	☐ Currently on Hemodialysis When:_____	☐ Currently on Peritoneal Dialysis When:_____
	☐ Kidney Disease When:_____	Other:_____		
Musculoskeletal	☐ None (Musculoskeletal) When:_____	☐ Back Pain (Chronic) When:_____	☐ Significant Neck Problems When:_____	☐ Arthritis When:_____
	☐ Gout When:_____	☐ Metal in your body When:_____	☐ Fibromyalgia When:_____	Other:_____
Mental / Emotional	☐ None (Mental / Emotional) When:_____	☐ Bipolar Disorder When:_____	☐ Alzheimer's When:_____	☐ Anxiety Disorder When:_____
	☐ Dementia When:_____	☐ Depression When:_____	☐ Psychiatric Diagnoses When:_____	Other:_____
Mobility / Vision / Hearing / Assistive Devices	☐ None (Assistive Devices) When:_____	☐ Currently Use a Cane or Walker When:_____	☐ Currently Use Wheelchair When:_____	☐ Currently Use Crutches When:_____
	☐ Have Prosthetic Device When:_____	☐ Use Hearing Aids When:_____	☐ Wear Glasses When:_____	☐ Wear Contact Lenses When:_____
	☐ Glaucoma When:_____	☐ Wear Dentures When:_____		

Previous Procedures

☐ None

☐ Implanted Cardiac Defibrillator When:_____	☐ Pacemaker Insertion When:_____	☐ Heart Valve Replacement When:_____	☐ Cardiac Stent When:_____	☐ Cardiac Surgery When:_____
☐ Angioplasty When:_____	☐ Coronary artery bypass surgery When:_____	☐ Carotid Stent When:_____	☐ Colon Resection When:_____	☐ Appendectomy When:_____
☐ Gallbladder removed When:_____	☐ Gastric Band When:_____	☐ Gastric By-Pass When:_____	☐ Hemorrhoidectomy When:_____	☐ Hernia Repair When:_____

- [ ] C-Section When:_____
- [ ] Hysterectomy When:_____
- [ ] Joint Replacement When:_____
- [ ] Mastectomy When:_____
- [ ] Prostatectomy When:_____
- [ ] Surgery When:_____
- [ ] Other: When:_____

Immunizations

- [ ] None

- [ ] Hep A When:_____
- [ ] Hep B When:_____
- [ ] Flu When:_____
- [ ] Pneumonia When:_____

Diagnostic Studies/Tests

- [ ] None

- [ ] Annual Labs — When:_____
- [ ] Colonoscopy — When:_____
- [ ] Duodenum Biopsy — When:_____
- [ ] EGD — When:_____
- [ ] ERCP — When:_____
- [ ] Esophageal Biopsy — When:_____
- [ ] Liver Biopsy — When:_____
- [ ] Stomach Biopsy — When:_____

Social History

Occupation:_____ Number of Children:_____

Marital Status

- [ ] Single
- [ ] Married
- [ ] Divorced
- [ ] Separated
- [ ] Widowed
- [ ] Civil Union
- [ ] Unknown
- [ ] Other

Alcohol

- [ ] None

- [ ] Rarely
- [ ] Daily
- [ ] More than 2 days/week
- [ ] Less than 2 days/week
- [ ] I quit using alcohol

Type:_____

Caffeine

- [ ] None

- [ ] Intake:_____

Tobacco

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

Type:_____

Drug Use

- [ ] None

- [ ] I am currently using recreational drugs
- [ ] I have used recreational drugs in the past
- [ ] I have been treated for substance abuse

Type:_____

Exercise

- [ ] None

Type Frequency

_____

Family Medical History

No knowledge of family history

No family history of Colon cancer Polyps

Diagnoses	Mother	Father	Sister	Brother	Grandmother	Grandfather
Ulcer Disease	○	○	○	○	○	○
Stomach Cancer	○	○	○	○	○	○
Colon Cancer	○	○	○	○	○	○
Colon Polyps	○	○	○	○	○	○
Colitis	○	○	○	○	○	○
Ulcerative Colitis	○	○	○	○	○	○
Crohn's Disease	○	○	○	○	○	○
Liver Disease	○	○	○	○	○	○
Alcoholism	○	○	○	○	○	○
Stroke	○	○	○	○	○	○
Heart Disease	○	○	○	○	○	○
Diabetes	○	○	○	○	○	○

Pharmacy

Name Address Phone

Consent to Import Medication History

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

Yes No

Consent to Share Data

I consent to having my medical and demographic information shared with other health care entities.

Yes No

Reminder Preference

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

Yes No

Reviewed with

Patient Parent Guardian Not Present

Signature

Signature Date