WESTSIDE GASTROENTEROLOGY ASSOCIATES

PLEASE FILL OUT COMPLETELY DATE ______________________

FIRST NAME MIDDLE LAST NAME FORMER LAST NAME (IF CHANGED)

ADDRESS STREET APT # CITY STATE COUNTY ZIP

SOCIAL SECURITY NUMBER DATE OF BIRTH AGE SEX

HOME PHONE CELL PHONE MARITAL STATUS

EMPLOYED BY OCCUPATION BUSINESS PHONE

EMPLOYERS ADDRESS CITY STATE ZIP

SPOUSE'S NAME SPOUSE'S EMPLOYER

REFERRAL AND PCP INFORMATION

REFERRED BY DR.____________________________PHONE________________________FAX________________________

PCP (PRIMARY CARE PROVIDER)________________________PHONE___________________FAX_____________________

EMERGENCY CONTACT (MANDATORY)

NEAREST FRIEND OR RELATIVE NOT LIVING WITH YOU RELATIONSHIP PHONE

INSURANCE____________________________(PRIMARY)______________________________(SECONDARY)

PLEASE COMPLETE SECTION BELOW IF YOU ARE *NOT* THE POLICY HOLDER

RESPONSIBLE PARTY

NAME DOB ADDRESS CITY STATE ZIP

HOME PHONE BUSINESS PHONE RELATIONSHIP SOCIAL SECURITY

WESTSIDE GASTROENTEROLOGY ASSOCIATES
HEALTH HISTORY FORM

Date__________________

Patient Name_____________________________ Date of Birth______________ Age_______
Referred by:_____________________________ Phone #_____________________________
Primary Care Physician:________________________ Phone #___________________________

1. Describe your current problem(s):

A.____

B.____

2. **History of Present Illness** (your current symptoms). Check all that apply.

❒ Heartburn
❒ Trouble Swallowing
❒ Painful swallowing
❒ Nausea/Vomiting
❒ Pain/Burning in stomach
❒ History of ulcers
❒ Vomiting blood
❒ Bloody stools
❒ Anemia (low blood count)
❒ Hepatitis/type___
❒ Jaundice
❒ Liver problems
❒ Pancreas problems
❒ Gallbladder problems
❒ Diarrhea
❒ Constipation
❒ Change in bowel habits
❒ Bloating
❒ Flatulence
❒ Weight loss
❒ Fever
❒ Lack of appetite
❒ Family history polyps
❒ Fam Hist colon cncr
❒ Family History ulcers
❒ Family Hist colitis
❒ Fam Hist gallstones

3. **Past History**
A. **Surgical** – Check all that apply. List year and any comments.
❒ Appendectomy_______
❒ Breast surgery_______
❒ Colon surgery________
❒ Gallbladder surgery____
❒ Heart_______________
❒ Brain_______________
❒ Hemorrhoidectomy______
❒ Hernia repair___________
❒ Hysterectomy__________
❒ Ovaries removed_______
❒ Joint replacement_______
❒ Spine_________________
❒ Stomach surgery___
❒ Thyroid surgery____
❒ Tonsillectomy______
Other______________

B. **Medical History** – Check all that apply. List the year and any comments.
❒ Hepatitis____________
❒ Other liver disease____
❒ Lung disease________
❒ Heart disease________
❒ High blood pressure____
❒ Stomach/intestine______
❒ Seizures_______________
❒ Cancer________________
❒ Arthritis________________
❒ Psychiatric_____________
❒ Diabetes_____________
❒ Glaucoma____________
❒ Enlarged prostate___
❒ Thyroid disorder____
❒ High cholesterol____
❒ Other_____________

C. **Allergies** ❒ Pcn ❒ Sulfa ❒ Codeine ❒ Latex ❒ Other_________________________

D. **Medications**

Name	Strength	How Often

E. **Do you take**:
- ❒ aspirin or arthritis medications
- ❒ blood thinners – Coumadin, Plavix
- ❒ Herbal supplements

4. **Family History**: F=father M=mother B=brother S=sister D=daughter S=son A=aunt U=uncle GP=grandparent

Colon cancer___________	Gallstones_______________	Stroke________________
Stomach cancer________	Heart disease____________	Tuberculosis___________
Colitis________________	High blood pressure______	Ulcerative colitis________
Colon polyps___________	Liver disease_____________	Stomach ulcers_________
Crohn's_______________	Mental disease____________	Other_________________
Diabetes______________	Pancreatitis_______________	

5. **Social History** (if yes, please indicate how much per day)

❒ Smoke_________(pk/day) ❒Drink coffee______(cups/day) ❒Drink milk__(glasses/day)
❒ Drink alcohol______(oz/day) ❒Drink tea_____(glasses/day)
❒ Drink carbonated beverages________

6. Review of Systems. Check all that apply

HEENT
- ❒ History of Nosebleeds
- ❒ Sinus/postnasal drip
- ❒ Ringing in ears
- ❒ Sore Throat
- ❒ Other____________

GYN
- ❒ Vaginal bleeding
- ❒ Vaginal discharge
- ❒ Lower abdominal pain
- ❒ Irreg vaginal bleeding
- ❒ Other______________

PSYCHOLOGICAL
- ❒ Inability to sleep
- ❒ Panic attacks
- ❒ Anxiety all the time
- ❒ Inability to think
- ❒ Other____________

PULMONARY
- ❒ Chronic cough
- ❒ Cough up blood
- ❒ Asthma/wheezing
- ❒ Short of breath
- ❒ Other____________

NEURO
- ❒ Dizziness
- ❒ Vertigo
- ❒ TIA
- ❒ Memory problem
- ❒ Other______________

DERMATOLOGIC
- ❒ Skin rash
- ❒ Hair loss
- ❒ Change in skin color
- ❒ Change in mole
- ❒ Itching
- ❒ Other_____________

CARDIAC
- ❒ Chest pain
- ❒ Palpitations
- ❒ Swollen ankles
- ❒ Short of breath lying down
- ❒ Other_________________

OPHTHALMOLOGIC
- ❒ Red eye
- ❒ Blurred vision
- ❒ Painful eye
- ❒ Blind spots
- ❒ Other______________

DENTAL
- ❒ Gum bleed
- ❒ Tooth pain
- ❒ Bad breath
- ❒ Sensitive teeth
- ❒ Loss of teeth
- ❒ Dentures/partials
- ❒Other______________

GI
- ❒ Nausea
- ❒ Vomiting
- ❒ Diarrhea
- ❒ Constipation
- ❒ Difficulty swallowing
- ❒ Other_____________

ENDOCRINE
- ❒ Hot/Cold
- ❒ Excessive thirst
- ❒ Excessive urination
- ❒ Significant weight gain/loss
- ❒ Other______________

MUSCULOSKELETAL
- ❒ Joint swelling
- ❒ Joint pain
- ❒ Pain not relieved by rest
- ❒ Spine pain
- ❒ Other______________

GU
- ❒ Painful urination
- ❒ Blood in urine
- ❒ Urethral discharge
- ❒ Urinate frequently
- ❒ Difficulty starting stream
- ❒ Other________________

HEMATOLOGIC
- ❒ Tired
- ❒ Irregular bleeding
- ❒ Easy bruising
- ❒ Blood clots
- ❒ Other_______________

Height________________ Weight_______________

7. **Additional information**

___

___

___

___

___

I have filled this form out to the best of my abilities as accurately as possible.

___

Patient Signature Date

Reviewed by Initials
❒ Jasmine Jeffers, MD_______________

WESTSIDE GASTROENTEROLOGY

FINANCIAL POLICY

WE ARE COMMITTED TO MEETING YOUR HEALTHCARE NEEDS. OUR GOAL IS TO KEEP YOUR INSURANCE OR OTHER FINANCIAL ARRANGEMENTS AS SIMPLE AS POSSIBLE. IN ORDER TO ACCOMPLISH THIS IN A COST-EFFECTIVE MANNER, WE ASK THAT YOU ADHERE TO THE FOLLOWING GUIDELINES:

1). PAYMENT IS EXPECTED AT THE TIME OF SERVICE, THIS INCLUDES CO-PAYS, DEDUCTABLES, PERCENTAGES AND SELF-PAY PATIENTS.

2). WE WILL FILE YOUR INSURANCE FOR YOU IF WE ARE A PARTICIPATING PROVIDER ON YOUR PLAN. YOU WLL BE RESPONSIBLE FOR ANY AND ALL SERVICES IN EXCESS OF YOUR INSURANCE LIMITS AS WELL AS ALL NON-COVERED SERVICES.

3). IF WE ARE NOT PARTICIPATING PROVIDERS OF YOUR PLAN, FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WE WILL GIVE YOU COMPLETE FORMS THAT WILL BE ACCEPTED BY YOUR INSURANCE COMPANY FOR REIMBURSEMENT.

4). WE WILL MAIL TO YOU A MONTHLY BILLING STATEMENT FOR ANY OUTSTANDING BALANCES.

5). ALL OUTSTANDING BALANCES GREATER THAN (30) DAYS WILL BE TRANSFERRED TO AN OUTSIDE COLLECTION AGENCY AND/OR LAW FIRM TO COLLECT THE AMOUNT DUE, WHICH IS TO INCLUDE BUT NOT LIMITED TO A FEE OF $20.00 AND POSSIBLE OTHER ADDITIONAL FEES.

I ACKNOWLEDGE THAT I HAVE READ, UNDERSTAND AND ACCEPT THIS FINANCIAL POLICY.

______________________________ _____/_____/_____
PRINTED NAME DATE

____
SIGNATURE

New policy as of 1/2008

<u>**WESTSIDE GASTROENTEROLOGY**</u>

Jasmine Jeffers, MD

Procedures/Lab Tests/Refills

If you have been set up for a test/procedure you must make a return visit two weeks after the date of your test to receive your results. Due to HIPAA regulations we do not give out any test results over the phone – no exceptions. This visit will allow the physician to answer any questions or concerns you may have, to adjust your medications if necessary, and to schedule additional tests if needed. This is a regular office visit, and you will be charged as your insurance indicates (co-pay, etc.).

All lab results, if normal, will be mailed within two weeks; if abnormal, you will be called to make a return visit.

We do not refill any pain medication/narcotics without an appointment. Please do not call the office or answering service for refills on these medications.

Please sign and date below that you have read and understand this document. Thank you.

X________________________________ Date_______________

Westside Medical Associates
Jasmine Jeffers, MD

Austell Office
3825 Medical Park Drive SW
Suite 300
Austell, Georgia 30106 - 1109

Phone: 770-941-4810
Fax: 770-948-9149

Acknowledgement of Receipt
of
"NOTICE OF PRIVACY PRACTICES"
for
Protected Health Information

I, acknowledge that I have received a copy of WESTSIDE MEDICAL ASSOCIATES "Notice of Privacy Practices" for Protected Health Information on the date set forth below.

____

Patient Name   Date of Receipt

____________________________________   ____________________________________

Print Name of Authorized Personal Representative   Signature of Authorized Personal Representative

____

Please Indicate Relationship to Patient

____

FOR USE BY WESTSIDE MEDICAL ASSOC. PERSONNEL ONLY: (Complete if Patient Acknowledgement is not obtained)

An Acknowledgement of Receipt of Notice of Privacy Practices was not obtained because:

[ ] Patient refused to sign Acknowledgement.

[ ] Unable to gain signed Acknowledgement due to communication/language or other barrier.

[ ] Patient was unable to sign Acknowledgement due to emergency treatment situation.

[ ] Other: Please indicate reason____

Signature of WESTSIDE MEDICAL ASSOCIATES Representative:_________________________________

Westside Medical Associates
Jasmine Jeffers, MD

Austell Office
3825 Medical Park Drive SW
Suite 300
Austell, Georgia 30106 - 1109

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