

Central Indiana Gastroenterology Group

Your appointment is scheduled for _____ at _____.
Please be sure to bring a list of any medications that you are currently taking with you for your first appointment.

If you have had any x-rays or laboratory studies that are pertinent to your current illness, please be sure your family physician faxes them to us **before your scheduled appointment**. If for any reason you are unable to keep the above appointment, we must be notified 24 hours in advance, as we do allow 30 minutes for your first visit. Due to the high demand for office visits with our doctors, we have instituted a dismissal policy for any patient who misses 3 scheduled appointments without giving our office 24 hour advance notice.

The fee for your first appointment will range from \$65 to \$304 depending on the type of examination or consultation that is done. Subsequent visits range from \$34 to \$156. We will file all charges with your insurance company at the conclusion of your office visit. While some companies pay fixed allowances for certain procedures, it is **your responsibility** to pay any deductible amount, co-payments, or any other balance not paid for by your insurance company. Co-payments and office visits not covered by insurance are to be paid on the day of service. **Self-pay patients are required to make a pre-determined partial payment prior to or on the day of service**, and the remaining balance will be set up on a payment plan. If this account is assigned to an attorney for collection and/or lawsuit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

Check with your insurance company to be sure we are a preferred provider for your particular insurance plan. Your doctor may be listed individually or under our group name. Please determine if Pre-Certification or a referral form is necessary for office or outpatient procedures.

To the extent necessary to determine liability for payments and to obtain reimbursement, I authorize disclosure of necessary portions of the patient's records.

I understand the above explanation of office appointments and fee policies.

SIGNED: _____ DATE: _____

If there are any questions regarding the above, please feel free to call our office, and we will be glad to assist you.

IT IS REQUIRED THAT THIS PAPERWORK BE COMPLETED AND RETURNED TO OUR OFFICE PRIOR TO YOUR OFFICE VISIT. IF YOU ARE HAVING A PROCEDURE, PLEASE RETURN THIS PAPERWORK WHEN SPECIFIED BY THE PHYSICIANS' ASSISTANTS. PLEASE DROP OFF PAPERWORK TO OUR OFFICE OR MAIL BACK IN THE ENCLOSED ENVELOPE. THANK YOU.

PATIENT RECORD

Date: _____

SSN: _____ - - .

Patient Name: _____ Date of Birth: _____ Age: _____ Sex: _____

Address: _____ Zip: _____ Home/Cell Phone: _____

Employer: _____ Work Phone: _____ Family MD: _____

Referred By: _____ Reason for Visit: _____ Date Symptoms Began: _____

Spouse Name: _____ Phone# _____ Spouse Employer _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

Primary Insurance: _____ ID#: _____ Group# _____ Ins. Telephone#: _____

Sec. Insurance: _____ ID #: _____ Group# _____ Ins. Telephone#: _____

Other Insurance: _____ ID#: _____ Group# _____ Ins. Telephone#: _____

Name of person carrying insurance: _____ Relationship: _____

Address: _____ Zip: _____ Phone #: _____

SSN: _____ - - Date of Birth: _____ Sex: _____ Employer: _____

Pharmacy: _____ Phone # _____ Hospital Preference: _____

Lab Preference: _____ Xray Preference: _____

You can leave medical information on answering machine or voicemail. Yes No

Patient History:

Marital Status: Single Married Separated Divorced Widowed

Race/Ethnicity: Caucasian African Am. Asian Hispanic Middle Eastern Other

Sexuality: Heterosexual Homosexual Bisexual

Housing: Live with family Live Alone Assisted care Nursing Home

Use of Alcohol: Never Rarely Moderately Daily

Use of Tobacco: Never Previously, but quit Currently; Packs per Day _____

Use of Drugs: Never Type/ Frequency _____

Excessive exposure at work or home to: Fumes Dust Solvents Airborne particles

Recent out of state trips: _____

Home care needs (ex.: wheelchair, C-PAP, etc.) _____

Medications: Include prescription and over the counter drugs such as eye drops, birth control pills, pain medications, hormone replacements, insulin, home oxygen, herbs, etc.

MEDICATION	DOSE	FREQ.	LAST DOSE

MEDICATION	DOSE	FREQ.	LAST DOSE

CONSTITUTIONAL SYMPTOMS

- Yes No Good general health lately
- Yes No Recent weight change
- Yes No Fever
- Yes No Fatigue
- Yes No Headaches

EYES

- Yes No Eye disease or injury
- Yes No Wear glasses/contact lens
- Yes No Blurred or double vision

Yes No **Glaucoma**

EARS/NOSE/MOUTH/THROAT

- Yes No Hearing loss or ringing
- Yes No Earaches or draining
- Yes No Chronic sinus problems
- Yes No Nose bleeds
- Yes No Mouth sores
- Yes No Bleeding gums
- Yes No Bad breath or bad taste
- Yes No Sore throat or voice change
- Yes No Swollen glands in neck

CARDIOVASCULAR

- Yes No Heart trouble
- Yes No Chest pain or angina
- Yes No Palpitation
- Yes No Shortness of breath
- Yes No Swelling of feet or ankles
- Yes No **High blood pressure**

RESPIRATORY

- Yes No Chronic or frequent cough
- Yes No Spitting up blood
- Yes No Asthma or wheezing
- Yes No **Lung disease**

GASTROINTESTINAL

- Yes No Loss of appetite
- Yes No **Change in bowel habits**
- Yes No Nausea or vomiting
- Yes No Frequent diarrhea
- Yes No Constipation
- Yes No Rectal bleeding or blood in stool
- Yes No Abdominal pain or heartburn
- Yes No **Peptic ulcer (stomach or duodenal)**
- Yes No Pancreatitis

GENITOURINARY

- Yes No Frequent urination
- Yes No Burning or painful urination
- Yes No Blood in urine
- Yes No Change in force of urine stream
- Yes No Incontinence or dribbling
- Yes No Kidney stones
- Yes No Sexual difficulty
- Yes No **Venereal Disease**
- Yes No Male- testicle pain
- Yes No Female- pain with periods

- Yes No Female-irregular periods
- Yes No Female- vaginal discharge
- Yes No Female- # pregnancies _____ #miscarriages _____
- Yes No Date of last Pap smear _____

MUSCULOSKELETAL

- Yes No Joint pain
- Yes No Joint stiffness or swelling
- Yes No Arthritis/Gout
- Yes No Weakness of muscles or joints
- Yes No Muscle pain or cramps
- Yes No Back pain
- Yes No Cold extremities
- Yes No Difficulty in walking

INTEGUMENTARY

- Yes No Rash or itching
- Yes No **TB/ TB exposure**
- Yes No **Change in skin color**
- Yes No Change in hair or nails
- Yes No Varicose veins
- Yes No Breast pain
- Yes No Breast lump
- Yes No Breast discharge

NEUROLOGICAL

- Yes No Frequent or recurring headaches
- Yes No Light headed or dizzy
- Yes No **Convulsions or seizures**
- Yes No Numbness or tingling sensations
- Yes No Tremors
- Yes No Paralysis
- Yes No **Stroke**
- Yes No Head injury
- Yes No **Sleep apnea**

PSYCHIATRIC

- Yes No Memory loss or confusion
- Yes No Nervousness
- Yes No Depression
- Yes No Insomnia
- Yes No **Mental illness**

ENDOCRINE

- Yes No Glandular or hormone problem
- Yes No Thyroid disease
- Yes No **Diabetes**
- Yes No Excessive thirst or urination
- Yes No Heat or cold intolerance
- Yes No Skin becoming dryer
- Yes No Change in hat or glove size

HEMATOLOGIC/LYMPHATIC

- Yes No Slow to heal after cuts
- Yes No **Bleeding or bruising tendency**
- Yes No Anemia
- Yes No Phlebitis
- Yes No Past transfusions
- Yes No Enlarged glands
- Yes No **Usual childhood diseases**

Allergies: List reactions or allergies to medications, food, latex, dyes or other:

ITEM	REACTION

ITEM	REACTION

Family Medical History

	Age	Diseases	If deceased, cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____

Patient Medical History

Infectious Diseases (ex: MRSA, VRE,): _____

Past and Present Diseases (ex: Cancer, Hepatitis, GERD, Diabetes, etc): _____

Weight change in last 3 months: _____ pounds increase decrease

Pregnant: If yes, Due Date: _____ Last menstrual period _____

Religious or Cultural Beliefs: _____

Yes No Implantable Devices: where _____

Yes No Body Piercing

Surgical History: List all surgeries you have had and approximate date.

SURGERY	DATE

SURGERY	DATE

Yes No Anticoagulant/Steroid Therapy in the past 6 months

Yes No Any Tranquilizers or nerve pills

Yes No Anesthesia complications List: _____

Yes No Family complications with anesthesia List: _____

I have reviewed the materials listed on pages 1-3 and agree that to the best of my knowledge, all information is correct at this time.

SIGNED _____ DATE _____

Insurance Authorization and Assignment

I authorize Central Indiana Gastroenterology Group to release information and submit insurance claim forms on my behalf for all services furnished on an inpatient or outpatient basis

As a service to our patients we will file your insurance claim.

In order to ensure you receive the full benefits of your insurance, it is your responsibility to know:

1. What hospital(s) you may use.
2. That our Doctor is in your insurance network.
3. What laboratory you may use.
4. If a paper referral form is needed from your PCP in order to be seen by us.
5. If a special referral is needed from your PCP in order to have additional testing and Procedures performed.
6. If a co-payment is required by your insurance at the time of service.

Please understand if you fail to comply with the guidelines your insurance company has set up, your benefits may be reduced and you will be responsible for paying any denied or non-covered charges.

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled including Medicare, private insurance, and other health plans for treatment expense to:

Central Indiana Gastroenterology Group,

Christopher A. Foster, M.D.
Jon M. Maier, M.D.

Rod A. Nisi, M.D.
Thomas V. Nowak, M.D.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

SIGNED _____ DATE _____