AZ GASTRO CARE

5555 E. Baseline Road, Mesa, AZ 85206 | P: 480.393.0575 | F: 480.704.4019
604 W. Warner Road Ste D1, Chandler, AZ 85225 |P: 480.393.0575 | F: 480.704.4019
4001 E. Baseline Rd. Ste 102-103 Gilbert, AZ 85234 |P: 480.565.8045
azgastrocare.com| email: admin@azgastrocare.com

PATIENT INFORMATION

Last Name First Name Middle Name		Date of Birth:	Sex [ ] M [ ] F
Mailing Address Apt/Lot City State/Zip		Primary Care Physician:	
Phone Number	Email:		
Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Widowed [ ] Separated		Social Security #:	
Race: [ ] Black [ ] White [ ] Asian [ ] Hispanic [ ] Other	Ethnicity: [ ] Hispanic [ ] Non Hispanic [ ] Unknown	Preferred Language:	
Spouse name:	Do you have a Living Will or Medical advanced Directive? [ ] Y [ ] N		
Emergency Contact:	Relationship:	Home Phone #:	
Emergency Contact Address:		Work phone #:	

INSURANCE INFORMATION

Primary Insurance:	Effective Date:	Secondary insurance:	Effective Date:
Policy Holder's Name:		Policy Holder's Name:	
Policy #	Group #	Policy #	Group #

RESPONSIBLE PARTY INFORMATION

Responsible Party Name	Date of Birth:	Relationship
Mailing Address apt/lot City State/Zip		Phone #

PHARMACY INFORMATION

Name of Pharmacy	Address/Cross Streets:	Phone #

AUTHORIZATION/CONSENT FOR TREATMENT

[ ] I assign all medical/surgical benefits to AZ Gastro Care and understand that I am financially responsible for all charges whether or not they are paid by insurance. I authorize payment to be made to the provider. In the event that the payment is made to the policyholder, I agree to submit payment in full to this office immediately. I the account is not paid in full, and prior arrangements have not been made, my account(s) may be referred to a collection agency. If my account is referred to an agency, I will be responsible for all attorney's and/or collection fees.

[ ] I hereby authorize the doctor to release or procure all information necessary to secure the payment, benefits, for treatment purposes, or to another healthcare provider or destination of my discretion. I may revoke this authorization at any time in writing, with the exception of insurance disclosures for billing purposes. I consent to communicate via electronic means for routine matters. I further agree that a photocopy of this agreement shall be as valid as the original. I certify the above information is true and correct to the best of my knowledge. I understand that HIPAA and privacy policies are available online and in the office by request. I authorize AZ Gastro Care to Evaluate, treat, and administer medications as appropriate.

[ ] I have read and understand the information on this form

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Patient/ POA Signature _____ Date _____

HIPAA NOTICES OF PRIVACY PRACTICES

AZ Gastro Care is required by law to maintain the privacy of your health information and provide you notice of our legal duties and privacy practice with respect to your health information. A copay of AZ Gastro Care Privacy Practices is available to you upon request. (Full HIPAA disclaimer is available upon request).

Patient/ POA Signature _____ Date _____

PATIENT CONSENT FOR RELEASE OF MEDICAL INFORMATION

In order to protect your confidentiality and to comply with government regulation (HIPAA), AZ Gastro Care is required to obtain authorization form you in order to leave messages and/or provide information regarding your care with any designated person, facility or physician.

Please list all others we are allowed to release information to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Messages and Phone Calls

I give my consent to the medical providers and staff of AZ Gastro Care to call and leave messages or discuss scheduling/appointments, treatment, surgery, blood work result or other information regarding my care as follows:

On Voicemail at home phone?	Yes	No
On voicemail on work phone?	Yes	No
On Voicemail on mobile Phone?	Yes	No
On Email provided?	Yes	No
To designated person?	Yes	No

Patient's Printed Name: _____ Date: _____

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Patient's Signature:

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PAST MEDICAL HISTORY

Gastrointestinal:	[ ] Gallstones	[ ] Ulcerative Colitis	[ ] Abnormal Liver Tests
[ ] Heartburn/GERD	[ ] Pancreatitis	[ ] Crohn's Disease	[ ] Fatty Liver Disease
[ ] Hiatal Hernia	[ ] Irritable Bowel Syndrome	[ ] Colon Polyps	[ ] Hepatitis A/B/C
[ ] Gastritis	[ ] Spastic Colitis	[ ] Colon cancer	[ ] Cirrhosis
[ ] H. Pylori	[ ] lactose intolerance	[ ] Anal Fissure	[ ] Liver Cancer
[ ] Ulcer	[ ] Diverticulosis/Diverticulitis	[ ] Anal Fistula	[ ] Liver Fibrosis
[ ] Celiac Disease	[ ] Hemorrhoids	[ ] Stool Incontinence	[ ] Pancreatic Cancer
Neuropsychiatric:	[ ] Seizures	[ ] Myasthenia Gravis	
[ ] Stroke	[ ] Migraines	[ ] Dementia	[ ] Bipolar Disorder
[ ] TIA (Mini-Stroke)	[ ] Chronic Headaches	[ ] Depression	[ ] Eating Disorder
[ ] Multiple Sclerosis	[ ] Parkinsons Disease	[ ] Anxiety	[ ] ADHD
Cardiovascular:	[ ] Tachycardia	[ ] PVC's	[ ] Rhythm Disorder
[ ] High Blood Pressure	[ ] Atrial Fibrillation	[ ] Mitral Valve Prolapse	[ ] Pacemaker
[ ] High Cholesterol	[ ] Heart Murmur	[ ] Rheumatic Fever	[ ] Defibrillator
[ ] Heart Attack	[ ] rhythm disorder	[ ] Congestive Heart Failure	[ ] Angina
Pulmonary:		[ ] Sarcoidosis	
[ ] Sleep Apnea	[ ] COPD	[ ] Pulmonary Embolism	[ ] Valley Fever
[ ] Asthma	[ ] Pneumonia	[ ] COVID	[ ] Lung Cancer
Hematologic:			
[ ] Anemia	[ ] Hemochromatosis	[ ] Blood Transfusion	[ ] Hodgkin's Disease
[ ] Leukemia	[ ] Lymphoma	[ ] Blood Clot	[ ] Myelodysplasia
Endocrine:	[ ] Thyroid Nodule	[ ] Goiter	
[ ] Diabetes Type 1	[ ] Hypothyroidism	[ ] Hashimoto's	[ ] Pituitary Disorder
[ ] Diabetes Type 2	[ ] Hyperthyroidism	[ ] Thyroid Cancer	[ ] Adrenal Disorder
Breast:	[ ] Breast Cancer		
[ ] Fibrocystic Breast	[ ] Right [ ] Left	[ ] Radiation	[ ] Chemotherapy
Genitourinary:			
[ ] Kidney Disease	[ ] Recurrent UTI	[ ] Prostate Enlargement	[ ] Ovarian Cysts/Cancer
[ ] Kidney Stones	[ ] Bladder Incontinence	[ ] Prostate Cancer	[ ] Uterine Fibroids/Cancer
[ ] Renal Cancer			
Musculoskeletal:			
[ ] Osteoarthritis	[ ] Osteoporosis	[ ] Fibromyalgia	[ ] Lupus
[ ] Rheumatoid arthritis	[ ] Osteopenia	[ ] Gout	[ ] Polymyalgia Rheumatica
EENT:			
[ ] Glaucoma	[ ] Macular Degeneration	[ ] Retinal Detachment	[ ] Sjogrens
[ ] Cataracts	[ ] Sinusitis	[ ] Allergic Rhinitis	[ ] Oral Thrush
Dermatologic:			
[ ] Eczema	[ ] Alopecia	[ ] Basal Cell Skin Cancer	[ ] Vitiligo
[ ] Psoriasis	[ ] Melanoma	[ ] Squamous Cell Cancer	[ ] Raynaud's Syndrome

SURGICAL/PROCEDURE HISTORY

[ ] Gallbladder	[ ] C-Section	[ ] Prostate Surgery	[ ] Heart Valve Surgery
[ ] Appendix	[ ] Tubal Ligation	[ ] Tonsillectomy	[ ] Pacemaker/Defibrillator
[ ] Groin Hernia Repair	[ ] Total Hysterectomy	[ ] Sinus Surgery	[ ] Bladder Surgery
[ ] Abdominal Hernia Repair	[ ] Partial Hysterectomy	[ ] Cataract Surgery	[ ] Colonoscopy
[ ] Bowel Obstruction	[ ] Ovarian Surgery	[ ] Knee Replacement [ ] R [ ] L [ ] B	[ ] Upper GI Endoscopy
[ ] Colon Resection	[ ] Uterine Ablation	[ ] Hip Replacement [ ] R [ ] L [ ] B	[ ] ERCP
[ ] Hemorrhoid Surgery	[ ] Breast Biopsy	[ ] Back Surgery	[ ] Others

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[ ] Anti-Reflux Surgery	[ ] Breast Lumpectomy	[ ] Cardiac Bypass Surgery	
[ ] Weight loss surgery	[ ] Breast Mastectomy [ ] R [ ] L	[ ] Stent / Angioplasty	

Current Medication

(Please include over-the-counter medications, vitamins, herbal supplements, hormone replacements and birth control pills)

Medication	Dose	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
Pain Medications:		

ALLERGIES

Are you allergic to Latex? [ ] Yes [ ] No

Medication/Food	Reaction	When

PREVIOUS GI PROCEDURES

Procedure	Date	Findings
Colonoscopy		
Upper GI Endoscopy		
ERCP		

Hospitalizations

Facility	Date	Findings

STAFF

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To complete social, smoking, alcohol history during check in