Patient information

Patient Name:	Date of birth:
Street Address:	Gender: ☐ Male ☐ Female
City, State, Zip:	Weight: / Height:
Home telephone:	Marital Status:
Alternate phone number: Work / Cell	Occupation:
May we leave messages on your answering machine? ☐ Yes ☐ No	
Name of Legally Responsible Representative:	
Relationship to Patient:	
Street Address:	
City, State, Zip:	Telephone:

Insurance Information

Company Name:	Patient Social Security #:
Name of primary insured:	ID number:
Claims Address:	Group number:
City, State, Zip:	Company Telephone:

Referring Physician Information

Physician Name:	Is this the primary care giver? ☐ Yes ☐ No
Street Address:	If not, name of PCP:
City, State, Zip:	Telephone:

Patient Medical History

*** please use back of form if more space is needed

ALLERGIES: (list all meds and reactions)

List all Present Illnesses/ Recent Diagnosis:

Have you ever had an endoscopic procedure? ☐ Yes ☐ No	Reason:	Date:

Past Medical History:

Past Surgical History:

CURRENT MEDICATIONS: (***list all medications including the dosage and frequency of use; include any vitamins/supplements, as well):

Do you take any of the following medications? Coumadin/ warfarin Plavix Aspirin NSAIDs

Do you have a personal or family history of any of the following: column 1 for personal hist; column 2 for fam.hist.

Abdominal Pain/ cramps	☐	☐	Heart Disease	☐	☐
Acid reflux/ heartburn	☐	☐	Hepatitis	☐	☐
Anemia	☐	☐	High Blood Pressure	☐	☐
Asthma or Lung Disease	☐	☐	High Cholesterol	☐	☐
Cancer (type)	☐	☐	Irritable Bowel Syndrome	☐	☐
Constipation	☐	☐	Kidney problems	☐	☐
Crohn’s disease	☐	☐	Mitral Valve prolapse	☐	☐
Diabetes	☐	☐	Nausea/ Vomiting	☐	☐
Diarrhea	☐	☐	Osteoporosis	☐	☐
Digestive disease	☐	☐	Polyps	☐	☐
Gastrointestinal Bleeding	☐	☐	Ulcers	☐	☐
GERD	☐	☐	OTHER:	☐	☐

I authorize the release of medical information which could include HIV status, communicable disease, or drug abuse information to and from my primary care and referring physician(s), outside laboratories or consultants, if needed, in the course of my examination and treatment and as necessary to process insurance claims, insurance applications and prescriptions until revoked in writing. I also authorize payment of medical benefits to the physician and Prospect Street Endoscopy OBS P.C.
By signing this form I assure the information provided is complete and accurate to the best of my knowledge. If any of the above information should change, I understand that it is my responsibility to inform the organization of such changes. I have received pre-procedure instructions. I have reviewed and understand, and a copy of the following information has been made available to me**: Information regarding the ownership of the practice; the expertise of the associated physicians; the Patient Rights and Responsibilities; the Patient Grievance Process; DNR policy; Notice of Privacy Practice.**

______________________________ ______________________________ ______________

Signature of Patient or Responsible Party | Printed Name | Date