PATIENT INFORMATION

Last Name: Prefix: Primary Physician:

First Name: Middle Initial: Referring Physician:

Address: Apt.: Date of birth:

City: State: Zip code: Marital status:

Home Phone: Cell Phone: Work Phone:

Preferred Number: Employer:

EMERGENCY CONTACT INFORMATION

Name: Relationship:

Street Address: Apt.: Home Phone:

City: State: Zip code: Cell Phone:

Work Phone:

May we speak to your Emergency Contact regarding test results:

GENERAL INFORMATION

E-MAIL Address: May we leave you voicemails:

Volunteer information for government reporting requirements:

Race:
Ethnicity:
Language:

PHARMACY INFORMATION

Local Pharmacy: Living Will:
Mail Order Pharmacy: Consent to patient Rx History:

FINANCIAL ASSIGNMENT AND AGREEMENT

1. It is my responsibility to pay any copays, deductibles or any other balance not paid for by my insurance. A No-Show Fee may apply to missed appointments. If a referral is needed for insurance, it is my responsibility to get that referral from my PCP.
2. I authorize the release of all medical information to process claims for medical care received. I assign all medical benefits, including major medical benefits to which I am entitled to Erieside Medical Group, Inc., this assignment is to be considered as valid as the original.
3. I am aware of the Erieside Medical Group, Inc. (HIPAA) Privacy Act and I understand I have the right to have a copy furnished to me upon request.
4. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.
5. PATIENT RIGHTS and RESPONSIBILITIES: A copy of your rights and responsibilities are posted and is available upon request.

Patient Signature: Date:

Patient Name: ______________________________ Date of Birth: ______________ ___

Reason for today's visit: __________ ______________________________

Current Medications– List **ALL** medications, **prescription, supplements**, and **over the counter** medications

Medication Name:	Dose and Frequency:	Reason for taking:

Medical History:

Anemia
Ascites
Asthma
Cancer Type:
Colitis
Colon Polyps
Crohn Disease
Depression
Diabetes
Diverticulosis
Emphysema or COPD
Endometriosis
Gallstones
Hepatitis Type:
High Blood Pressure
High Cholesterol
HIV
Irritable Bowel Syndrome
Kidney Stones
Liver Disease
Low Blood Pressure
Migraine Headaches
Pancreatitis
Peripheral Vascular Disease
Seizures
Sleep Apnea
Stomach Ulcer
Stroke/TIA
Thyroid Disease
Other:

Allergies, sensitivities, reactions:

Past Surgical History:

Year:

Abdominal Surgery Type:
Appendectomy
Cancer Surgery Type:
Cosmetic Surgery Type:
Colon Surgery Type:
Gallbladder removal
Hemorrhoid Removal
Hernia: Type:
Hysterectomy (TAH)
Hip Surgery
Knee Surgery
Shoulder Surgery ______________
Any other metal in body
Laparoscopy
Tonsillectomy ______________
Other

Anesthesia Questionnaire:

Year:

Any past problems with anesthesia?
Atrial fibrillation
CABG (Coronary artery bypass grafting)
Congestive / Chronic heart failure
Defibrillator - Date last checked:
Have you been told you are a difficult intubation
Heart Attack
Heart Stents
Heart valve replacement
Kidney failure / Dialysis
Organ transplant
Oxygen therapy
Pacemaker - Date last checked:
Shortness of breath with (1) flight of stairs
Cardiologist (Heart) Phy:
Pulmonologist (Lung) Phy:
Nephrologist (Kidney) Phy: _____

Recent Hospitalization - non-surgical

Family Medical History – If yes, please list the relation and age:

Colon Cancer
Colon Polyps
Inflammatory Bowel Disease
Cancer of:
- Endometrial
- Esophagus
- Kidney
- Ovarian
- Pancreas
- Small Bowel
- Stomach

Social History:

Marital Status:
Children: ______
Use of Alcohol:
Recreational Drug Use:
Use of Nicotine/Tobacco:

Gastrointestinal
Nausea
Vomiting
Heartburn
Food sticking in throat
Painful swallowing
Vomiting blood
Black stool
Red blood in stool
Abdominal pain
Constipation
Diarrhea
Loss of appetite
Early satiety
Bloating
Hemorrhoids

Constitutional
Recent weight gain
# of pounds____
Recent weight loss
# of pounds ____
Fever
Fatigue

HEENT
Sore throat
Hoarseness

Cardiovascular
Abnormal heart rhythm
Chest pain
Palpitations

Respiratory
Cough
Shortness of breath on exertion
Shortness of breath at rest
Wheezing

Genitourinary
Frequent urination
Kidney failure/dialysis
Painful urination

Neurological
Seizures
Headaches

Dermatology
Rash

Musculoskeletal
Joint Pain
Arthritis

Psychiatric
Dementia
Depression
Anxiety

Height:
Weight:

GI History: When: Physician Who Performed:

Have you had a previous colonoscopy?
Have you had a previous EGD?

Authorization and Release:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the office of any changes in my medical status. I authorize the healthcare staff to perform necessary services I may need and release information to others if necessary for my care.

Signature of Patient: **Date:**

CONSENT FOR RELEASE OF INFORMATION
(Please Print or Type)

I HEREBY AUTHORIZE ______________________________ OF ______________________________
Doctor or Facility Street Address

______________________ ______________________ ______________________
City State Zip Code

______________________ ______________________
Phone Number Fax Number

TO RELEASE THE FOLLOWING INFORMATION OF PATIENT:

______________ ______________ ______ ______________ ______________
Last Name First Name Initial DOB Social Security #

______________ ______________ ______________ ______
Street Address City State Zip

____
Phone Number

Name(s) of the physician(s) who treated you: ______________________________

____

Covering the period of ______________________ **to** ______________________
Date **Date**

INFORMATION TO BE RELEASED:

__________ **All Records** Reason for Disclosure: ______________________

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INFORMATION TO BE RELEASED TO:

ERIESIDE MEDICAL GROUP, INC.
ATTN: ______________________ (Physicians Name)
38429 Lakeshore Boulevard
Willoughby, Ohio 44094
Phone - 440-946-9200
Fax – 440-946-1000

This consent will remain for ninety (90) days unless a specific date, event or condition is specified:

____

The facility, its employees and physicians are released from legal responsibilities or liabilities for the release of the above information to the extent indicated and authorized herein.

______________________________ ______________________
Signature of Patient **Date of Signature**

______________________________ ______________________
Signature of Patient Representative **Date of Signature**

(Medical records from other facilities in our possession will not be re-released)
(Allow 5-10 working days for request to be processed)
RUSH REQUEST MUST BE CLEARED BY MEDICAL LEGAL

PROHIBITATION OF REDISCLOSURE
THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS PROTECTED BY FEDERAL CONFIDENTIALITY RULES (42 CPR PAR 2). YOU SHALL MAKE NO FURTHER DISCLOSURE OF THIS INFORMATION WITHOUT THE SPECIFIC WRITTEN AND INFORMED CONSENT OF THE INDIVIDUAL TO WHOM IT PERTAINS, OR AS OTHER WISE PERMITTED BY STATE AND FEDERAL LAW.