PATIENT INFORMATION

Last Name: ______ Prefix: ______ Primary Physician: ______

First Name: ______ Middle Initial: ______ Referring Physician: ______

Address: ______ Apt.: ______ Date of birth: ______

City: ______ State: ______ Zip code: ______ Marital status: Single/ Married Divorced/ Widowed

Home Phone: ______ Cell Phone: ______ Work Phone: ______

Preferred Number: Home or Cell ______ 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: Y or N

GENERAL INFORMATION

E-MAIL Address: ______ May we leave you voicemails: Y or N

Volunteer information for government reporting requirements:

Race: White Hispanic African American American Indian Other Race

Ethnicity: Hispanic or Latin Not Hispanic or Latin Refused to Report

Language: English Spanish Russian Other ______

PHARMACY INFORMATION

Local Pharmacy: ______ Living Will: Y or N

Mail Order Pharmacy: ______ Consent to patient Rx History: Y or N

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:

Condition		
Anemia	No	Yes
Ascites	No	Yes
Asthma	No	Yes
Cancer Type: ______________	No	Yes
Colitis	No	Yes
Colon Polyps	No	Yes
Crohn Disease	No	Yes
Depression	No	Yes
Diabetes	No	Yes
Diverticulosis	No	Yes
Emphysema or COPD	No	Yes
Endometriosis	No	Yes
Gallstones	No	Yes
Hepatitis Type: ______________	No	Yes
High Blood Pressure	No	Yes
High Cholesterol	No	Yes
HIV	No	Yes
Irritable Bowel Syndrome	No	Yes
Kidney Stones	No	Yes
Liver Disease	No	Yes
Low Blood Pressure	No	Yes
Migraine Headaches	No	Yes
Pancreatitis	No	Yes
Peripheral Vascular Disease	No	Yes
Seizures	No	Yes
Sleep Apnea	No	Yes
Stomach Ulcer	No	Yes
Stroke/TIA	No	Yes
Thyroid Disease	No	Yes
Other: ______________	No	Yes

Allergies, sensitivities, reactions: ☐ **Check If None**

Past Surgical History:

Surgery				Year:
Abdominal Surgery Type: ______________		No	Yes	
Appendectomy		No	Yes	
Cancer Surgery Type: ______________		No	Yes	
Cosmetic Surgery Type: ______________		No	Yes	
Colon Surgery Type: ______________		No	Yes	
Gallbladder removal		No	Yes	
Hemorrhoid Removal		No	Yes	
Hernia: Type: ______________	Any Mesh ______	No	Yes	
Hysterectomy (TAH)		No	Yes	
Hip Surgery	Metal or Plastic	No	Yes	
Knee Surgery	Metal or Plastic	No	Yes	
Shoulder Surgery	Metal or Plastic	No	Yes	
Any other metal in body ______________		No	Yes	
Laparoscopy		No	Yes	
Tonsillectomy		No	Yes	
Other ______________		No	Yes	

Anesthesia Questionnaire:

Question			Year:
Any past problems with anesthesia?	No	Yes	
Atrial fibrillation	No	Yes	
CABG (Coronary artery bypass grafting)	No	Yes	
Congestive / Chronic heart failure	No	Yes	
Defibrillator - Date last checked: __________	No	Yes	
Have you been told you are a difficult intubation	No	Yes	
Heart Attack	No	Yes	
Heart Stents	No	Yes	
Heart valve replacement	No	Yes	
Kidney failure / Dialysis	No	Yes	
Organ transplant	No	Yes	
Oxygen therapy	No	Yes	
Pacemaker - Date last checked: __________	No	Yes	
Shortness of breath with (1) flight of stairs	No	Yes	

Cardiologist (Heart) Phy: ______________________

Pulmonologist (Lung) Phy: ______________________

Nephrologist (Kidney) Phy: ______________________

RECENT HOSPITALIZATIONS NON-SURGICAL ☐ Check If None

Family Medical History – If yes, please list the relation and age: ☐ **Check If None**

Colon Cancer No Yes ______
Colon Polyps No Yes ______
Inflammatory Bowel Disease No Yes ______

Cancer of:

Endometrial No Yes ______
Esophagus No Yes ______
Kidney No Yes ______
Ovarian No Yes ______
Pancreas No Yes ______
Small Bowel No Yes ______
Stomach No Yes ______

Social History:

Marital Status: ◻ - Single ◻ - Married ◻ - Separated ◻ - Divorced ◻ - Widowed
Children: ◻ - No ◻ - Yes - How Many? ______
Use of Alcohol: ◻ - None ◻ - Yes - How Much? ______
Recreational Drug Use: ◻ - No ◻ - Yes - If Yes, Drug Type: ______
Use of Nicotine/Tobacco: ◻ – Never ◻ – Quit ◻ - Yes ◻ - Smoking ◻ – Chewing ◻ – E-Cigarettes - How Much? ______
If Yes to Quit, How long ago? ______

Are you having any of the following symptoms:

Gastrointestinal

Nausea No Yes
Vomiting No Yes
Heartburn No Yes
Food sticking in throat No Yes
Painful swallowing No Yes
Vomiting blood No Yes
Black stool No Yes
Red blood in stool No Yes
Abdominal pain No Yes
Constipation No Yes
Diarrhea No Yes
Loss of appetite No Yes
Early satiety No Yes
Bloating No Yes
Hemorrhoids No Yes

Constitutional

Recent weight gain No Yes
# of pounds ____
Recent weight loss No Yes
# of pounds ____
Fever No Yes
Fatigue No Yes

HEENT

Sore throat No Yes
Hoarseness No Yes

Cardiovascular

Abnormal heart rhythm No Yes
Chest pain No Yes
Palpitations No Yes

Respiratory

Cough No Yes
Shortness of breath on exertion No Yes
Shortness of breath at rest No Yes
Wheezing No Yes

Genitourinary

Frequent urination No Yes
Kidney failure/dialysis No Yes
Painful urination No Yes

Neurological

Seizures No Yes
Headaches No Yes

Dermatology

Rash No Yes

Musculoskeletal

Joint Pain No Yes
Arthritis No Yes

Psychiatric

Dementia No Yes
Depression No Yes
Anxiety No Yes

Height:______
Weight:______

GI History: **When:** **Physician Who Performed:**

Have you had a previous colonoscopy? No Yes
Have you had a previous EGD? No Yes ______

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.