Digestive Health Specialists

Registration Information:

LAST NAME: _____FIRST NAME: _____MI:_____

ADDRESS (including PO BOX): _____ _____

CITY: _____STATE: _____ZIP CODE: _____

CELL PHONEץ_____ ALTERNATE PHONE: _____ EMAIL: _____

DATE OF BIRTH: _____AGE: _____SEX: M F (CIRCLE) SOCIAL SECURITY #: _____

OCCUPATION:_____ MARITAL STATUS: M W S D (CIRCLE)

SPOUSE'S NAME:_____SPOUSE DOB:_____

ETHNICITY:☐Hispanic or Latino ☐Non-Hispanic or Latino☐ Not provided LANGUAGE: ☐ English ☐Spanish Other: _____

RACE:☐White ☐Black or African American☐ Asian ☐American Indian or Alaskan ☐Hawaiian or Pacific Islander ☐Not provided

REFFERING/PRIMARY PHYSICIAN: _____PHONE #: _____

PHARMACY: _____ PHARMACY CITY AND STREET_____

Contact Information:

Do you have a Power of Attorney for health care decisions? □yes □no.

If yes, provide name and phone number of your POA:_____

IF PATIENT IS A MINOR, PLEASE PROVIDE NAME OF PARENTS/GUARDIAN:_____

EMERGENCY CONTACT NAME: _____ RELATIONSHIP:_____PHONE #:_____ ____

Insurance Information:

ACCORDING TO MY INSURANCE, I AM RESPONSIBLE TO PAY A COPAY AMOUNT OF $_____

****MY INSURANCE REQUIRES A REFERRAL FROM MY PCP (primary care provider) BEFORE I SEE A SPECIALIST. YES ☐ NO ☐**

PRIMARY INSURANCE NAME: _____IS THE PRIMARY INSURED PERSON:(CIRCLE ONE) SELF SPOUSE PARENT

CARDHOLDER NAME: _____D.O.B.: _____

CARDHOLDER ID#: _____GROUP#_____

CARDHOLDER EMPLOYER NAME _____WORK PHONE_____

SECONDARY INSURANCE NAME: _____IS THE SECONDARY INSURED PERSON: (CIRCLE ONE) SELF SPOUSE PARENT

CARDHOLDER NAME: _____D.0.B.: _____

CARDHOLDER ID #: _____ GROUP#_____

CARDHOLDER EMPLOYER NAME_____WORK PHONE_____

The above information is accurate to the best of my knowledge. I authorize Digestive Health Specialists to furnish information to my insurance carrier concerning my illness and treatment. If you fail to pay on time and Digestive Health Associates (AKA Digestive Health Specialists) refers your account(s) to a third party for collection, a collection fee of 33.3% will be assessed and will be due and owing at the time of the referral to the third party. I understand that I will be liable for collection costs, bank charges, and attorney's fees in the event *Digestive Health Specialists,* must take action against me because I have failed to pay any balance due upon demand or because any payment is returned to my financial institution. Proper venue for any such actions will be in the Circuit Court of Grundy County, Illinois or Circuit Court of Will County, Illinois. **I understand that it is my personal responsibility to verify whether medical services are covered under my health insurance policy** and I am responsible for payment in full for these services in the event that said services are not covered or are ultimately denied by my health insurance company for any reason.

SIGNATURE: _____DATE: _____

PRINT NAME: _____ Relationship if other than patient: _____

Digestive Health Specialists
Medical Questionnaire

Instructions: This medical questionnaire will assist us in understanding your medical status. Please answer all questions fully, printing or writing legibly. If you are uncertain about a question or answer, use a question mark(?). Thank you!

Todays Date:_____Patient Name:_____ Date of Birth:_____

SOCIAL HISTORY

Stress Issues- □work □recent trauma □Illness in family □relationship issues □family issues

Comments: _____

Tobacco- □N/A □current □previously(year quit_____) □cigarettes □chew tobacco □cigars □amount:_____

Alcohol- □N/A □beer □wine □liquor □how often? _____

Caffeine- number of cups per day: _____

Diet- Are you on a special diet? □Diabetes □Cardiac □Celiac Sprue □Lactose Free □low fat □other:_____

Recreational Drugs- □N/A □ _____

MEDICATIONS – list all prescription and non-prescription medications you presently take including aspirin, vitamins, herbs, dietary supplements, calcium, laxatives, etc, *AND THE REASON YOU ARE TAKING THE MEDICATION* (attach additional pages if necessary)

Medicine:	Dosage:	how often per day?	Prescribing Physician:	Reason for use:

ALLERGIES – List all allergies to drugs, medicines, bee sting, etc and give reaction. **Are you allergic to latex? □yes □no**

Have you been advised to take antibiotics before medical or dental procedures? □yes □no

Are you allergic to Penicillin? □yes □no **Are you allergic to shell fish?** □yes □no

Drug/agent	Reaction	Drug/agent	Reaction

PREVIOUS GI EVALUATIONS – give the year, location (hospital name or office name) and, if known, the result of the following medical studies:

	Year	Facility where test was performed	Result (circle NL if normal and ? if unknown)
colonoscopy			NL ? polyps
Upper endoscopy (EGD)			NL ?
Abdominal CAT (CT) scan			NL ?
Abdominal Ultrasound			NL ?
Barium Enema			NL ?
Upper GI xray series			NL ?

OPERATIONS – List all surgical operations (especially abdominal, hernia, hemorrhoids, hysterectomy, cardiac, heart valve, pacemaker, artificial joints, cataracts) Give the year, physician and location

Operation	year	physician	hospital, city, state

GASTROINTESTINAL FAMILY HISTORY*- check all that apply

	Colon cancer	Colon polyps	Ulcerative colitis	Crohns Disease	Irritable Bowel Syndrome	Liver Disease
Mother	□	□	□	□	□	□
Father	□	□	□	□	□	□
Paternal Grandfather	□	□	□	□	□	□
Paternal Grandmother	□	□	□	□	□	□
Maternal Grandfather	□	□	□	□	□	□
Maternal Grandmother	□	□	□	□	□	□
Brothers #_____	□	□	□	□	□	□
Sisters #_____	□	□	□	□	□	□
Sons # _____	□	□	□	□	□	□
Daughters #_____	□	□	□	□	□	□

*Please add any other important family health history_____

_____

FAMILY HISTORY – Please provide the following information on your parents, siblings and children

Circle male or female	Age if Living	Check if healthy	Age at death	Major Illness and/or cause of death
Father				
Mother				
Sibling: M/F				
Sibling: M/F				
Sibling: M/F				
Sibling: M/F				

Circle male or female	Age if living	Check if healthy	Age at death	Major Illness and/or cause of death
Child: M/F				
Child: M/F				
Child: M/F				
Child: M/F				
Child: M/F				
Child: M/F				

Digestive Health Specialists

Past Medical History

Please circle conditions **you have been diagnosed with**:

Gastrointestinal

GERD
Barrett's Esophagus
Peptic Ulcer Disease
Esophageal Rings
Irritable Bowel Syndrome
Celiac Disease
Crohn's Disease
Ulcerative Colitis
Pancreatic Cancer
Lactose Intolerance
Liver Disease
Pancreatitis
Bowel Obstruction
Gastrointestinal Bleeding (diverticular, AVM, ulcers)
Colon Polyps
Colon Cancer
Esophageal Cancer
Gastric Cancer
Other:

Cardiovascular

Hypertension
Hyperlipidemia
Coronary Artery Disease
Congestive Heart Failure
Atrial Fibrillation
Arrhythmia
Valvular Heart Disease (specify)
Other:

Respiratory

Asthma
COPD
Lung Cancer
Sleep Apnea
Other:

Rheumatological

Osteoarthritis
Rheumatoid arthritis
Vitamin D Deficiency
Osteopenia/Osteoporosis
Fibromyalgia
Other:

Urological

Frequent/Recurring UTI's
Kidney Stone
Chronic Kidney Disease
End Stage Renal Disease (HD/PD)
Kidney Cancer
Other:

Endocrinological

Hyperthyroid
Hypothyroid
Parathyroid Disease
Diabetes Type 1
Diabetes Type 2
Other:

Reproductive

Pregnancy
STD's
Enlarged Prostate
Impotence
Breast Cancer
Uterine Cancer
Cervical Cancer
Prostate Cancer
Other:

Psychiatric

Depression
Anxiety
Sexual/Physical Abuse
OCD
Bulimia
Anorexia
Other:

Neurological

Seizure Disorder
Migraines
Chronic Headaches
Stroke (CVA/TIA)
Neuropathy
MS
Other:

Dermatological

Psoriasis
Eczema
Skin Cancer (BCC/SCC)
Melanoma
Acne
Other:

Eyes

Glaucoma
Cataracts
Retinopathy
Other:

Heme/Onco

Anemia
Iron Deficiency
B12 Deficiency
Pernicious Anemia
Hx of Blood Transfusion
Leukemia
Lymphoma
DVT
PE
Clotting Disorders
Cancer:_____
Other:

DIGETIVE HEALTH SPECIALISTS

RELEASE OF HEALTH INFORMATION AND TEST RESULTS

To ensure proper and timely handling of your test results which have been ordered by your health care provider, please fill out the following information:

Patient's Name: _____Date of Birth: _____

Address: _____SSN: _____

Home Phone: _____Work Phone: _____Cell Phone: _____

I authorize Digestive Health Specialists to release any and all medical test results or other medical information relating to my treatment to:

Please initial your choice(s):

____May leave a message at work to call the office.

____May leave a message on voicemail to call the office.

____May leave a message with a family member to call the office.

____May give results to designated person:

____May only release test results to myself.

Name: _____Relation: _____

I understand this release will be in effect unless changed or revoked by myself in writing.

Patient Signature: _____Date: _____

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

Digestive Health Specialists is required to provide you with a copy of our "Notice of Privacy Practices", which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of this Notice.

I acknowledge that I have received a copy of the office's Notice of Privacy Practices.

Patient Signature: _____Date: _____

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CONSENT TO OBTAIN ELECTRONIC MEDICATION HISTORY

I understand that my medication history may be obtained utilizing an electronic information exchange and that this protected health information may provide valuable information to my healthcare provider. I hereby authorize Digestive Health Specialists to access my mediation history without limitation or exclusion as is required and/or reasonably advisable to disclose, process, retrieve, transmit, and view for the purpose of the transmission of an electronic prescription issued by a provider authorized by law to prescribe, as necessary for my care and treatment

Patient Signature: _____Date: _____

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DIGESTIVE HEALTH SPECIALIST PATIENT PORTAL

Please provide your email address for access to Digestive Health Specialists Patient Portal.

Email address: _____

AUTHORIZATION
To Use and Disclose Health Information

Patient's Name: _____Date of Birth: _____ SS#_____
Address:_____
Telephone Number: ( )_____

I hereby authorize the use and disclosure of the individually identifiable health information about me that is described below by **Digestive Health Specialists** for the specific purpose listed below. I understand that such uses and disclosures may only be made by, and only to , the persons or organizations identified below, and that **Digestive Health Specialists** is not receiving any remuneration from any third parties as a result of this use or disclosure of information.

I understand that **Digestive Health Specialists** may not and will not condition health care treatment or payment, or enrollment in a health plan or eligibility for health care benefits, upon my signing this authorization for the requested use and disclosure. I further understand that if the person or organization to whom this information is disclosed is not a health plan or health care provider, or if the information does not relate to a federally-funded substance abuse program, the information may no longer be protected by federal privacy law and regulations after disclosure. In such a case, the information may be redisclosed by the recipient to others for other purposes. I understand that I may, at any time, inspect or obtain a copy of the information about me that will be used and disclosed, as described below, by mailing a written request to the address give below or presenting it in person at **Digestive Health Specialists.**

<u>This section to be filled out by Office Staff</u>

Specific description of health Information to be used or disclosed _____
_____
(e.g. if not specifically limited or restricted, the types of information to be used or disclosed may include medical, psychiatric, or psychological records of evaluation and treatment for alcohol or drug abuse*, records of HTLV-HI, HIV, or AIDS testing, etc.)

Approximate dates of treatment: _____
Purpose or the use of disclosure: _____
Persons or organizations using or disclosing the information : _____
Persons or organization receiving the information: **<u>Digestive Health Specialists, 1715 N Division St. Ste. A, Morris, IL 60450 ph. 815-942-1550 fax 815-942-8419</u>**

I understand that my decision to sign this form and authorize this use and disclosure of health information about me, as described above is entirely voluntary and that I may refuse to sign this form. I understand that I may revoke this authorization, in writing, at any time. However, such a revocation will not be effective for uses or disclosures that have already been made or other actions that have already been taken, in reliance on this authorization or as required by law. I may make such a written revocation by mailing it to the address given below or presenting it in person at Digestive Health Specialists. I also understand that I may request a copy of Digestive Health Specialists Notice of Privacy Practices, or ask any other questions, by calling Digestive Health Specialists' Privacy Officer Manager, at any time in order to learn more about how information about me is used or disclosed by Digestive Health Specialists or about revocation of this authorization.
Unless revoked by me sooner or limited or restricted to a shorter time period by applicable law, this authorization shall be effective for _____ days/months/years (complete blank and circle appropriate period) after the date of my signing below. I understand that I am entitled to a copy of this authorization after signing below, and if signing in person at Digestive Health Specialists, I will ask for such a copy, if one is not provided, before I leave.

I ACCEPT THESE TERMS AND AUTHORIZE THE ABOVE USE AND DISCLOSURE

SIGNATURE _____ DATE:_____

WITNESS SIGNATURE _____DATE: _____

DIGESTIVE HEALTH SPECIALISTS

Morris Center for Digestive Health

Richard Rotnicki, D.O., FACG, FACOI
Board Certified Gastroenterology

Our Midlevel Providers:

Lucinda DeWaele-Guzman APRN

Jeff Aguilar, PA-C

Locations:

1715 N Division St
Suite A
Morris, IL 60450
815-942-1550
815-942-8419 FAX

1310 Houbolt Rd.
Joliet, IL 60431
815-942-1550
815-942-8419 FAX

Cancellation Policies

OFFICE VISITS:

There will be a $50.00 charge for EVERY missed appointment.
Please notify the office **24hrs *PRIOR TO*** your appointment date to cancel your appointment to avoid any fees. 3 or more "no show" appts will be cause for dismissal from the practice. **PLEASE NOTE ARRIVING 15MIN (OR MORE) LATE TO AN APPT IS CONSIDERED A NO SHOW AND YOUR APPOINTMENT WILL NEED TO BE RESCHEDULED.

PROCEDURES:

There will be a $100.00 charge for any missed procedures.
Please notify the office **48hrs *PRIOR TO*** your scheduled procedure date to cancel your procedure to avoid any fees.

I, _____, understand that the above cancellation fees will not be covered by my insurance and I will be solely responsible for payment. Any balance after 90 days will be sent to collections and reported to the credit bureau.

Patient Signature: _____

Date: _____