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Patient Interview Form

First Name: _____ Last Name: _____

Date of Birth: _____ Email: _____

Race (Select one or more)

- ⬭ White
- ⬭ Black or African American
- ⬭ Asian
- ⬭ American Indian or Alaska Native
- ⬭ Native Hawaiian or other Pacific Islander
- ⬭ Unknown
- ⬭ Patient Declines to specify
- ⬭ Prohibited by State Law

Ethnicity

- ⬭ Hispanic or Latino
- ⬭ Not Hispanic or Latino
- ⬭ Patient Declines to specify
- ⬭ Prohibited by state law

Sex

- ⬭ Male
- ⬭ Female
- ⬭ Other

Preferred Language

- ⬭ English
- ⬭ Spanish; Castilian
- ⬭ Patient declines to specify

Contact Preference (Choose ONE)

- ⬭ Cell Phone
- ⬭ Telephone call-Home
- ⬭ Patient Portal

Preferred Pharmacy

_____

Name of Pharmacy Address Phone

Consent to Import Medication History
I consent to the practice obtaining a history of my medications purchased at pharmacies.

◯ Yes ◯ No

Consent to Share Data
I consent to having my medical and demographic information shared with other health care entities involved in my care.

◯ Yes ◯ No

Reminder Preference
I would like to receive preventive care and follow-up care reminders.

◯ Yes ◯ No

Allergies (Please list all food and drug allergies)

◯ None

_____ _____ _____ _____

_____ _____ _____ _____

Pneumonia vaccine?

◯ Yes, when: _____
◯ No

Current Medications

◯ None

Name Dose Directions

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Diagnostic Studies/ Tests

◯ None

◯ Colonoscopy
Date: _____
Other: _____

◯ EGD (Endoscopy)
Date: _____
Other: _____

◯ Flexible Sigmoidoscopy
Date: _____

◯ CT Abdomen/Pelvis
Date: _____

◯ HIDA Scan
Date: _____

Past or Present Medical Conditions

◯ None				
◯ Anemia When: _____	◯ Colon polyp history When: _____	◯ Arthritis When: _____	◯ Asthma When: _____	◯ Colon Cancer When: _____
◯ C.O.P.D. When: _____	◯ Diverticulosis When: _____	◯ Diverticulitis When: _____	◯ HIV When: _____	◯ Hemorrhoids When: _____
◯ Hepatitis A When: _____	◯ Hepatitis B When: _____	◯ Hepatitis C When: _____	◯ Gastroesophageal Reflux Disease (GERD) When: _____	◯ Hypothyroidism When: _____
◯ Diabetes, Non-Insulin Dependent When: _____	◯ Diabetes Mellitus, Insulin Dependent When: _____	◯ Depression When: _____	◯ Migraines When: _____	◯ Kidney Failure When: _____
◯ Sleep apnea When: _____	◯ Seizures When:_____	◯ Rheumatic Fever When: _____	◯ TB Exposure When: _____	◯ Ulcer Disease When: _____
◯ Renal Failure When: _____	◯ MRSA When: _____	◯ Liver Disease When: _____	◯ Currently Pregnant	
Cardiac History	◯ Acid Reflux When: _____	◯ Acute MI When: _____	◯ Angina When: _____	◯ Anticoagulation Therapy When: _____
	◯ Atrial Fibrillation When: _____	◯ Defibrillator When: _____	◯ Heart Attack When: _____	◯ Heart Murmurs When: _____
	◯ High Blood Pressure When: _____	◯ High Cholesterol When: _____	◯ Carotid Artery Disease When: _____	◯ Pacemaker When: _____
	◯ Stroke When: _____	◯ Chest Pain When: _____	◯ Stent Placement When: _____	
Cardiologist Name: _____	Other:_____	Other: _____	Other: _____	

Previous Procedures

◯ None				
◯ Appendectomy When: _____	◯ Hysterectomy - Abdominal When: _____	◯ Hysterectomy - Transvaginal When: _____	◯ Gallbladder Removed - Open When: _____	◯ Gallbladder Removed - Laparoscopic When: _____
◯ Bariatric Surgery When: _____	Other: _____	Other: _____	Other: _____	Other: _____

Social History

Occupation: _____ Number of Children: _____

Marital Status

◯ Single ◯ Married ◯ Divorced ◯ Separated ◯ Widowed ◯ Civil Union ◯ Other

Alcohol Use

◯ None

Type Quantity Frequency

_____

Tobacco Use

◯ Current every day smoker ◯ Current some day smoker ◯ Former smoker ◯ Heavy Tobacco Smoker ◯ Light Tobacco Smoker ◯ Never smoker

Type Started Quit Quantity Frequency

_____

Illegal Drug Use

◯ None

Type Frequency

_____

Family Medical History

○ No Knowledge of family medical history

	None	Mother	Father	Sister	Brother	Daughter	Son	Other
Family History of Colon Cancer	○	○	○	○	○	○	○	○
Family History of Colon Polyps	○	○	○	○	○	○	○	○

Review of Systems (Please check all CURRENT symptoms)

Constitutional		
○ None	**Y**	**N**
Fatigue	○	○
Fever	○	○
Night sweats	○	○
Anorexia	○	○
Chills	○	○

Eyes		
○ None	**Y**	**N**
Double vision	○	○
Blurred vision	○	○

ENMT		
○ None	**Y**	**N**
Dizziness	○	○
Ringing in ears	○	○
Hearing loss	○	○
Nose bleeds	○	○
Hoarseness	○	○

Respiratory		
○ None	**Y**	**N**
Coughing up blood	○	○
Cough	○	○
Wheezing	○	○
Sputum Production	○	○

Cardiovascular		
○ None	**Y**	**N**
Shortness of breath	○	○
Chest pain	○	○
Palpitations	○	○

Gastrointestinal		
○ None	**Y**	**N**
Painful swallowing	○	○
Difficulty swallowing	○	○
Rectal Bleeding	○	○
Black tarry stools	○	○
Diarrhea	○	○
Constipation	○	○
Abdominal Pain	○	○
Weight loss	○	○
Gas	○	○
Change in bowel habits	○	○
Yellowing of the skin/Jaundice	○	○
Nausea	○	○
Stomach cramps	○	○
Vomiting	○	○
Abdominal bloating	○	○
Heartburn	○	○
Weight gain	○	○

Genitourinary		
○ None	**Y**	**N**
Frequent urination	○	○
Urgency of urination	○	○
Hesitancy of urination	○	○
Blood in urine	○	○
Pain with urination	○	○
Incontinence	○	○

Psychiatric		
○ None	**Y**	**N**
Anxiety	○	○
Depression	○	○

Musculoskeletal		
○ None	**Y**	**N**
Muscle pain	○	○
Joint pain	○	○
Joint swelling	○	○

Neurological		
○ None	**Y**	**N**
Seizures	○	○
Loss of consciousness	○	○
Fainting	○	○
Headaches	○	○

Integumentary		
○ None	**Y**	**N**
Jaundice	○	○
Rashes	○	○
Allergies	○	○
Lesions	○	○

Endocrine		
○ None	**Y**	**N**
Excessive thirst	○	○
Hot or cold intolerance	○	○

Allergic /Immunologic		
○ None	**Y**	**N**
Persistent infections	○	○
Strong allergic reactions or urticaria	○	○

Hematologic/Lymphatic		
○ None	**Y**	**N**
Bleeding gums or palpable lymph nodes	○	○
Easy bruising	○	○
Prolonged bleeding	○	○

○ **NO SYMPTOMS**

Optimal Digestive Care
Patient Demographic Sheet

Patient Name: _____
(LAST) (FIRST) (MIDDLE)

Date of Birth: _____ Age: _____ Sex: ☐ Male ☐ Female

Home Phone No.: _____ Cell Phone No.: _____

Work Phone No.: _____ Social Security No.: _____

E-Mail Address: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home Address: _____
(Street) (P.O. Box) (City) (State) (Zip)

Employer: _____ Occupation: _____

Employer Address: _____

Spouse's Name: _____ Spouse's Date of Birth: _____

Spouse's Social Security No.: _____ Spouse's Cell Phone No.: _____

Spouse's Employer: _____ Spouse's Work Phone No.: _____

Insurance Company Name: _____ Plan Effective Date: _____

Subscriber's Name: _____ Relationship to Patient: _____

Subscriber's Date of Birth: _____ Other Insurance Coverage: _____

Family Doctor: _____

Emergency Contact Person: _____ Relationship to Patient: _____

Emergency Phone No.: _____

PLEASE READ: All charges or co-pays are due at the time of service. Please present your insurance card(s) and driver's license to the office staff with this completed form. We will copy for our records and return them to you immediately.

Consent for Treatment: I authorize Optimal Digestive Care to perform examinations, procedures, laboratory tests, and to administer such medications as, in his opinion, are necessary for my care; and to access my records at Frederick Memorial Hospital or in the possession of other health care providers.

I acknowledge receipt of Optimal Digestive Care "Notice of Privacy Practices."

_____ _____
Patient Signature Date

Please read carefully and sign the section that applies to you:

Non-Medicare patients:

- All charges are due at the time professional services are rendered.
- The patient is responsible for all fees.
- The fee ticket may be used to file insurance claims.
- I hereby authorize Optimal Digestive Care to furnish information to any insurance company or authorized agency specified regarding information concerning my medical care.
- For those services provided and submitted to my insurance company, I hereby authorize payment of medical benefits to Optimal Digestive Care

I verify that the insurance information provided is complete and correct as of this date.

Signature: _____ Date: _____

Medicare Patients Only:

I authorize release to Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I also understand that I am responsible for the deductible, coinsurance, and any non-covered services as determined by Medicare

Signature: _____ Date: _____

Medicare Supplemental Insurers' MEDIGAP Assignment of Benefits:

Section 4081 of the Omnibus Budget Reconciliation Act of 1987 provides an additional participation incentive for participating physicians by providing payment directly for assigned Medicare Supplemental (MEDIGAP) insurance benefits.

I understand my signature gives authorization for my physician to bill claims directly to my recognized MEDIGAP insurance carrier and for payments to be received directly. This allows for medical information to be forwarded to the insurance carrier as necessary.

The explanation of Medicare Benefits received from Medicare will display the following message to notify you that a claim has been submitted to your MEDIGAP carrier: *"Because you have assigned MEDIGAP benefits, information regarding your claim will be sent to your private insurer within 30 days."* I also understand that any deductibles, coinsurances, and non-covered services will be my responsibility.

Signature: _____ Date: _____

Authorization for Verbal Disclosure of Medical Information

I, _____ give Optimal Digestive Care permission to discuss the following:

Diagnosis, prognosis, and/or treatment information
Test results
Scheduling information
Billing information
Other (please specify): _____

With the following person(s):

_____ Relationship: _____

_____ Relationship: _____

I authorize Optimal Digestive Care to:

Leave messages on my home answering machine
Leave messages on my personal cell/mobile phone
Leave messages on my work answering machine/voicemail
Leave messages with my family members or others residing in my household

_____ _____

Patient Signature Date

Note: This form must be filled out completely in order for Optimal Digestive Care to ensure the privacy and confidentiality of our patients' protected health information. The instructions on this form will be considered current until a new Authorization for Verbal Disclosure of Medical Information supersedes them. It is the patients' responsibility to file a new form with Optimal Digestive Care if there are changes in your household situation. Optimal Digestive Care is not responsible for undesired communication resulting from the failure of a patient to file a new Authorization for Verbal Disclosure of Medical Information Form.

(**PLEASE TURN OVER)**

Optimal Digestive Care

FINANCIAL POLICY

Optimal Digestive Care is committed to providing you with the best possible care. Your clear understanding of our Financial Policy is important to our professional relationship. We ask that you read the policy, agree to, and sign it prior to treatment. Please ask if you have any questions about our fees or your financial responsibility.

Your insurance benefit is based on a contract between you and your insurance company. It is your responsibility to ensure that the insurance information is accurate and up to date. As a courtesy, we will file your claim provided you assign benefits to the doctor; in other words, you agree to have your insurance pay us directly. For your convenience, our billing is handled through Professional Accounts Management Service. They are available Monday through Friday from 8:00 a.m. until 4:00 p.m. You may reach them by calling toll free 1-888-313-9539. Their knowledgeable staff will be happy to address any questions you may have regarding our financial policy, your claims, and/or your account.

Managed Care Plans

Your insurance company may require that you contact your Primary Care Physician when medical care is needed. You may need to obtain a health plan referral form from your Primary Care Provider prior to being seen by a specialist. If this is a requirement of your insurance carrier, it is **your responsibility** to obtain the referral and/or authorization prior to your visit with our office. If you have questions regarding your insurance company's regulations, please contact them for the proper procedure.

Co-payments, Deductibles and Account Balances

By law, we must collect your designated co-payment at the time of service. Please be prepared to pay that amount at each visit. You are responsible for any deductible and/or balance your plan indicates on their EOB (explanation of benefits). Balance is due within **30 days** from date of service.

Optimal Digestive Care requires a credit card on file. Your credit card information is stored in an encrypted Cardpointe system which meets the Payment Card Industry Data Security Standards (PCI/DSS). The remaining allowed amount due to Optimal Digestive Care (co-payment/deductible/coinsurance/non-covered amounts) as patient's responsibility will be charged to your card on file if not paid within 30 days.

Self Pay

If you have no insurance, payment is expected in full at the time of service. A deposit is required prior to scheduling any procedure.

Missed Appointments

Broken appointments represent a cost to us, to you, and to other patients who could have been seen within the time set aside for you. A 24 hour cancellation notice is required for an office appointment. Failure to give such notice may result in a "missed office appointment fee" of $50.00. Procedures must be cancelled at least 3 days in advance or a $100.00 procedure cancellation fee is due.

Returned Checks/ Declined Credit Card Payment

For checks returned to us as unpaid by your bank, you will be charged a $50.00 fee. For Credit Card payments received by mail that are declined, a $30.00 fee will be charged.

Delinquent Accounts

By providing a wired and/or wireless telephone number you agree, in order for us to service our account or to collect any amounts you may owe, we, our agents, assignees, third party(s) servicing agent(s) or its third party debt collectors may contact you by telephone at any telephone number associated with your account and/or number provided by you, including but not limited to wired or wireless telephone numbers, which could result in charges to you. Your also agree all to allow us, our agents, assignees, third party(s), servicing agents or its third party debt collectors to communicate with you to include text messaging, e-mail, facsimile, and any other electronic communications. You also agree that Methods of contact may include the use of pre-recorded/artificial voice messages and/or use of an automated telephone dialing device or system, as applicable. You agree that we, our agents, assignees, third party(s) or servicing agent(s) and third party debt collectors may, for training purposes or to evaluate the quality of service, may listen to and record phone conversations you have with us and/or our agents, assignees third party(s) or servicing agent(s) or third party

I have read, understand, and agree to the above financial policy. If my account becomes assigned to a collection agency, I agree to pay a 25% collection fee, interest in the amount of 18%, court costs, and attorney fees, as allowed by law.

_____ _____

Signature of Patient and/or Guardian (SEAL) **DATE**