Etowah Gastroenterology Associates
Vipul T. Amin, M.D.

Patient Information

PATIENT NAME (LAST, FIRST, MIDDLE)				PRIMARY TELEPHONE		SECONDARY TELEPHONE	
ADDRESS		CITY		STATE		ZIP CODE	
PATIENT'S EMPLOYER				OCCUPATION (INDICATE IF STUDENT)		WORK TELEPHONE	
SEX ☐M ☐F	RACE	AGE	MARTIAL STATUS ☐S ☐M ☐D ☐W	BIRTHDATE	RETIRED ☐Y ☐N	DISABLED ☐Y ☐N	SOCIAL SECURITY NO.
SPOUSE'S NAME				SPOUSE'S EMPLOYER		SPOUSE'S WORK TELEPHONE	
NEXT OF KIN (NOT LIVING WITH YOU)						DAYTIME TELEPHONE	
FRIEND (NOT LIVING WITH YOU)						DAYTIME TELEPHONE	
WHOM MAY WE CONTACT IN CASE OF EMERGENCY						DAYTIME TELEPHONE	
REFERING PHYSICIAN				FAMILY PHYSICIAN			
PHARMACY/CITY		PREFERRED LANGUAGE		ETHNICITY		EMAIL ADDRESS	
PERSON RESPONSIBLE FOR PAYMENT				RELATION TO PATIENT			
ADDRESS	CITY	STATE	ZIP CODE	PRIMARY TELEPHONE		SOCIAL SECURITY NO.	
BIRTHDATE	EMPLOYER			WORK TELEPHONE			
NAME OF PRIMARY INSURANCE CO.		CONTRACT NO.		GROUP NO.		EFFECTIVE DATE	
NAME OF INSURED (AS IT APPEARS ON YOUR INSURANCE CARD)							
NAME OF SECONDARY INSURANCE CO.		CONTRACT NO.		GROUP NO.		EFFECTIVE DATE	
NAME OF INSURED (AS IT APPEARS ON YOUR INSURANCE CARD)							

I (Or my legal guardian or parent) authorize Etowah Gastroenterology Assoc. to provide medical care reasonable by today's standards.

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO Etowah Gastroenterology Associates, P.C. of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but not to exceed the physician's regular charges for these services. I understand that I am financially responsible to Etowah Gastroenterology Assoc., P.C. for charges not covered by this assignment. I authorize the refund of overpaid benefits where my coverage's are subject to coordination of benefits. In the event of default, I agree to pay all costs of collection including reasonable attorney's fees, and waiver all claims of exemption under the law of the State of Alabama.

By signing this form, you are granting consent to Etowah Gastroenterology Assoc. to use and disclose your protected health information for the purposes of treatment, payment, and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent and we encourage you to read it in full. Our Notice of Privacy Practices is subject to change. If we change out notice, you may obtain a copy of the revised notice by contacting our organization at (256) 467-4477. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment, or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Signature of patient/legal guardian: _____ Date_____

PERMISSION TO DISCLOSE PROTECTED HEALTH INFORMATION
CONSENT AND ACKNOWLEDGEMENT FOR
ETOWAH GASTROENTEROLOGY ASSOCIATES, P.C.
(PLEASE PRINT)

Patient Name: _____ Date of Birth: _____
Patient Address: _____ SSN: _____
_____

I give Etowah Gastroenterology Associates, P.C. permission to release medical information to the follow persons:

☐ None-Patient Only ☐ Children_____
☐ Parents _____ ☐ Spouse _____
☐ Father (only) _____ ☐ Mother (only) _____
☐ Other _____ ☐ Guardian _____
☐ Physicians _____ Fax # _____ Phone # _____

I wish to be contacted in the following manner by Etowah Gastroenterology Associates, P.C. (check all that apply):

☐ **Home Telephone** _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call back number only

☐ **Cell Phone** _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call back number only

☐ **Work Telephone** _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call back number only

☐ **Written Communication**
- ☐ O.K. to mail or Email to my home address
- ☐ O.K. to mail or Email to my work/office
- ☐ O.K. to fax to this number

☐ **Other (Email Address)** _____
_____
_____
_____
_____

The Privacy Act generally requires healthcare providers to take responsible steps to limit the use of disclosure of and requests for protected health information to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of protected health information disclosures. Information provided below, if completed properly, will constitute an adequate record.

Consent:
I consent to the use and disclosure of protected health information about me by my physician and my physician's practice for purposes of treatment, payment, health care operations, protection of others and disclosures required by law, including information about notifiable diseases, sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) and human immunodeficiency virus (HIV).

NOTE: Uses and disclosures for protected health information may be permitted without prior consent in an emergency.

ACKNOWLEDGMENTS:
I acknowledge that I have received Etowah Gastroenterology Associates, P.C. Notice of Privacy Practices.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Relationship of Personal Representative to the Patient Signature of Witness

_____
Print Personal Representative's Name

Etowah Gastroenterology Associates

1026 Goodyear Ave, Suite 201 • Gadsden, AL 35904 Tel (256) 467-4477 • Fax (256) 467-4830
Vipul Amin, M.D.

Name: _____ Date of Birth: _____ Age_____
Referring Physician: _____
CHIEF COMPLAINT (*describe in your own words the main reason you are seeing the doctor today)*: _____

MARK ALL SYSTEMS OR CONDITIONS THAT YOU CURRENTLY HAVE

GASTROINTESTINAL

- ☐ Nausea
- ☐ Belching
- ☐ Abdominal Pain
- ☐ Get Full Quickly at Meals
- ☐ Vomiting
- ☐ Blood in Stool
- ☐ Abdominal Swelling
- ☐ Diarrhea
- ☐ Black Stool
- ☐ Painful Swallowing
- ☐ Change in Bowel Habits
- ☐ Constipation
- ☐ Gas / Flatulence
- ☐ Vomiting Blood
- ☐ Food / Milk Intolerance
- ☐ Bloating
- ☐ Laxative Use
- ☐ Difficulty Swallowing
- ☐ Pain with Bowel Movement
- ☐ Heartburn

☐ NONE

Have you had any of these procedures?

- Colonoscopy: ☐ Yes Year: _____ / Physician: _____ ☐ No
- Upper Endoscopy: ☐Yes Year: _____ / Physician: _____ ☐ No
- CT scan of abdomen (past 6 months): ☐ Yes ☐ No
- Ultrasound of abdomen (past 6 months): ☐ Yes ☐ NO

GENERAL
- ☐ Lack of Appetite
- ☐ Tiredness
- ☐ Night Sweats
- ☐ Fever
- ☐ Weight loss (over 10lbs)
- ☐ NONE

HEENT
- ☐ Wear glasses
- ☐ Wear contacts
- ☐ Hoarseness
- ☐ Decreased Hearing
- ☐ Headache
- ☐ NONE

GENITOURINARY
- ☐ Change in urinary stream
- ☐ Blood in urine
- ☐ Difficulty urine
- ☐ Pelvic pain
- ☐ NONE

DERMATOLOGY/SKIN
- ☐ Rashes
- ☐ Itching
- ☐ NONE

MUSCULOSKELETAL
- ☐ Physical Disability
- ☐ Joint stiffness
- ☐ Back pain
- ☐ NONE

CARDIOVASCULAR
- ☐ Fainting/Blacking out
- ☐ Swelling of Hands or Feet
- ☐ Chest pain
- ☐ Leg cramping
- ☐ Irregular heartbeats
- ☐ NONE

NEUROLOGICAL
- ☐ Dizziness
- ☐ Fainting
- ☐ Loss of Consciousness
- ☐ Weakness in Extremities
- ☐ Seizure
- ☐ Difficult Speech
- ☐ NONE

ENDOCRINOLOGY
- ☐ Cold Intolerance
- ☐ Excessive thirst
- ☐ Heat intolerance
- ☐ Change of appetite
- ☐ Frequent Urination
- ☐ NONE

RESPIRATORY
- ☐ Chronic Cough
- ☐ Difficulty Breathing
- ☐ Wheezing
- ☐ NONE

BREAST
- ☐ Breast Pain
- ☐ Breast Mass
- ☐ NONE

PYSHIATRIC
- ☐ Suicidal Thoughts
- ☐ Anxiety
- ☐ Depression

OB/GYN
- ☐ Menstrual abnormality

Are you currently pregnant?
Yes☐ No☐
Last menstrual period
date: _____

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MEDICAL HISTORY

Name: _____Date of Birth _____ Age __ Date_____

PRESENT MEDICATIONS:

List all prescription and nonprescription medications you are currently taking

_____
_____
_____
_____
_____
_____

DRUG ALLERGIES:

List any allergy or previous drug reactions

_____
_____
_____

ALLERGIES

☐ Anaphylactic or Other Reaction to Anesthesia
☐ Contrast or Iodine Allergy
☐ Latex Rubber Allergy

MARK ALL CONDITIONS THAT YOU HAVE HAD

GASTROINTESTINAL CONDITIONS

☐ Celiac Disease or Sprue
☐ Irritable Bowel Syndrome
☐ Stomach Ulcer or Duodenal Ulcer
☐ Barrett's Esophagus
☐ Other: _____
☐ Hiatal Hernia
☐ Acid Reflux / GERD
☐ Cirrhosis
☐ Esophageal Stricture or Narrowing
☐ Colon Polyps
☐ Diverticulitis
☐ Diverticulosis
☐ NONE

NON- GASTROINTESTINAL CONDITIONS

☐ Congestive Heart Failure
☐ Abnormal Heartbeat / Palpitations
☐ Diabetes
☐ Blood Clots
☐ High Blood Pressure
☐ Thyroid Disease
☐ Asthma
☐ Sleep Apnea
☐ Heart Disease / Heart Attack
☐ Bleeding Disorder
☐ High Cholesterol
☐ NONE
☐ Lupus
☐ Seizure Disorder
☐ Stroke
☐ Arthritis
☐ Emphysema or COPD
☐ Other: _____

CANCER HISTORY

☐ Esophageal
☐ Stomach
☐ Uterine
☐ NONE
☐ Ovarian
☐ Colon or Rectal
☐ Pancreatic
☐ Other: _____
☐ Liver
☐ Prostate
☐ Breast

SURGERIES

☐ Pacemaker Placement
☐ Appendectomy
☐ Heart Valve Replacement
☐ Gastric Bypass / Lap Band
☐ Hysterectomy
☐ Coronary Bypass (Open Heart)
☐ Gallbladder Removal
☐ Back Surgery
☐ Stomach Ulcer
☐ Colon Resection
☐ Cardiac Stent
☐ NO SURGERIES

Other surgery not listed:

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Name: _____ D.O.B. _____

FAMILY HISTORY

Family History Unknown ☐ Adopted ☐

Have any of your blood relatives had COLON CANCER OR COLON POLYPS?

COLON CANCER

YES	NO	
☐	☐	Mother
☐	☐	Father
☐	☐	Sister
☐	☐	Brother
☐	☐	Daughter
☐	☐	Son
☐	☐	Other

COLON POLYPS

YES	NO	
☐	☐	Mother
☐	☐	Father
☐	☐	Sister
☐	☐	Brother
☐	☐	Daughter
☐	☐	Son
☐	☐	Other

OTHER FAMILY HISTORY:

Fill in the box if a relative (parent, grandparent, sibling, children, aunt or uncle) has had any of the following, mark "NONE" if none apply.

☐ Celiac Disease
☐ Diabetes
☐ Uterine Cancer
☐ Ovarian Cancer
☐ Other Cancer
☐ Breast Cancer
☐ Stomach Cancer
☐ Liver Cancer
☐ Crohn's Disease
☐ NONE
☐ Pancreatitis
☐ Bleeding Disorder
☐ Hemochromatosis
☐ Ulcerative Colitis

SOCIAL HISTORY:

- Have you ever had a blood transfusion? Yes ☐ Year: _____ No ☐
- Do you smoke? Yes ☐ No ☐
  - approximate amount per day: _____
- Do you use other tobacco products? Yes ☐ No ☐
- Do you drink alcohol: Yes ☐ No ☐
  - approximate amount per day: _____
- Have you ever used any intravenous drugs? Yes ☐ No ☐
- Have you ever had any tattoos/body piercings? Yes ☐ No ☐
- Have you traveled outside of the US in the past year? Yes ☐ No ☐ If so, where? _____
- FOR FEMALE PATIENTS:
  - Are you currently pregnant? Yes ☐ No ☐
  - Last menstrual period date: _____

Etowah Gastroenterology Associates

HIPAA FORM

Request for Restrictions on Uses/Disclosures of Health Information

DATE: _____

BY LAW, All medical information is confidential unless written authorization is given. Therefore, by signing this form, I _____ am authorizing ETOWAH GASTROENTEROLOGY ASSOCIATES to give medical information to:

_____DO NOT DISCLOSE ANY MEDICAL INFORMATION TO ANYONE OTHER THAN MYSELF

Signature of Patient

THIS REMAINS IN EFFECT UNTIL I GIVE WRITTEN NOTIFICATION TO DISCONTINUE

Signature of Patient DATE