DIGESTIVE DISEASE SPECIALISTS, INC.
INSTITUTE OF DIGESTIVE DISEASE
DDSI AEC SOUTH LLC

PATIENT INFORMATION

DATE: _____

FULL LEGAL NAME (No Nicknames)

DDSI PROVIDER: _____

☐ MR. ☐ MRS. ☐ MS. ☐ MISS

LAST NAME_____FIRST_____MI____ PREFERRED NAME_____

DATE OF BIRTH_____ AGE_____ SEX (circle one) M F SOCIAL SECURITY NUMBER_____

PATIENT RACE ☐ Amer. Indian/Alaskan ☐ Asian ☐ Black/African Amer. ☐ Nat. Hawaiian/Pacific Islander ☐ White/Caucasian ☐ Other ☐ Declined

PATIENT ETHNICITY ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined

PRIMARY LANGUAGE ☐ English ☐ Spanish ☐ Vietnamese ☐ Declined ☐ Other_____

MARITAL STATUS ☐ Single ☐ Married ☐ Life Partner ☐ Legally Separated ☐ Divorced ☐ Widowed ☐ Declined

ADDRESS_____CITY_____ST_____ZIP_____

HOME PHONE_____ BUSINESS PHONE_____ CELL PHONE_____ FAX NUMBER _____

(WHICH IS THE BEST NUMBER TO REACH YOU? ☐ HOME ☐ CELL ☐ BUSINESS)

EMAIL_____

PATIENT'S EMPLOYER_____ PATIENT'S POSITION_____

BUSINESS ADDRESS_____

SPOUSE'S NAME_____ SPOUSE'S EMPLOYER_____

SPOUSE'S WORK PHONE_____SPOUSE'S CELL PHONE_____

PERSON RESPONSIBLE FOR BILL (IF OTHER THAN ABOVE)

NAME_____ RELATIONSHIP_____

(IF OTHER THAN PATIENT)

ADDRESS_____

HOME PHONE NUMBER_____ CELL PHONE NUMBER_____

EMPLOYER_____ POSITION_____

BUSINESS ADDRESS_____ BUSINESS PHONE_____

NEAREST RELATIVE TO NOTIFY IN AN EMERGENCY (OTHER THAN SPOUSE)

NAME_____ RELATIONSHIP_____

HOME PHONE_____ WORK PHONE_____ CELL PHONE_____

PREFERRED METHOD OF COMMUNICATION

☐ HOME PHONE ☐ CELL PHONE ☐ MAIL ☐ PATIENT PORTAL

PREFERRED PHARMACY

1. LOCAL PHARMACY – NAME, ADDRESS, PHONE, FAX_____
2. MAIL IN PHARMACY – NAME, ADDRESS, PHONE, FAX_____

INSURANCE INFORMATION (PLEASE BRING INSURANCE CARDS AT TIME OF SERVICE)

NOTICE: IF YOU'RE A CURRENT HOSPICE PATIENT PLEASE CHECK BOX ☐

PRIMARY INSURANCE

POLICY HOLDER_____ DOB_____ SS#_____

INSURANCE COMPANY_____ GROUP #_____ POLICY #_____

INS CO ADDRESS_____ TELEPHONE #_____

POLICY HOLDER'S EMPLOYER/PHONE #_____

SECONDARY INSURANCE

POLICY HOLDER_____ DOB_____ SS#_____

INSURANCE COMPANY_____ GROUP #_____ POLICY #_____

INS CO ADDRESS_____ TELEPHONE #_____

POLICY HOLDER'S EMPLOYER/PHONE #_____

REFERRAL SOURCE

REFERRED BY (circle one): PROVIDER (NAME)_____ FRIEND; FAMILY; ACQUAINTED WITH PROVIDER; ACQUAINTED WITH STAFF; YELLOW PAGES; HEALTH PLAN; REFERRAL SERVICE; OTHER_____

DIGESTIVE DISEASE SPECIALISTS, INC.

(Institute of Digestive Disease Specialists, Inc, DDSI South AEC, LLC, Digestive Disease Pathology, LLC)

FINANCIAL RESPONSIBILITY POLICY

In seeking medical care you obligate yourself to compensate the physician for their services. As a patient of Digestive Disease Specialists, Inc (DDSI), you are required to fill out and sign all forms prior to being seen by the physician. Failure to do so may require your appointment to be rescheduled.

Account Information…It is your responsibility to notify the office of any name, address, or phone number changes. If you are unable to keep an appointment, please notify the office as soon as possible to prevent a possible no show fee.

Insurance…You are required to provide your insurance card so that it can be scanned into our system. It is your responsibility to notify us if your insurance changes. Insurance companies have a filing deadline, so failure to provide us with the correct insurance information at the time of service may result in your being responsible for the entire bill. Please check with your insurance to determine if the doctor you are seeing is a contracted provider. All copays will be collected at the time of service. You are responsible for any deductibles, denials, etc. and agree to submit payment to DDSI immediately upon notification of responsibility from your insurance company. In the event that your insurance company denies payment for services rendered, you will be personally and fully responsible for those charges. Failure to comply can result in your account being turned to a collection agency and possible termination as a patient from the group.

Payment Prior to Services Rendered…Patients are provided cost of service and informed that payment is required at time of service or service will be re-scheduled.

Anesthesia…Patients that receive anesthesia (Propofol) will receive a separate bill for anesthesia services.

Patient Credits…Overpayments of co-insurance or deductibles may occasionally result in a credit balance on a patient account. DDSI issues a refund check to the patient for any credit balances in excess of $9.99 and upon the patient's request if less than $9.99.

Non-Insured Patients…You are expected to make 50% of the procedure cost at time the appointment is scheduled and 50% on the day of procedure. **NOTE: You will be receiving a separate bill for anesthesia and may receive separate charge should you require pathology.**

Forms of Payment…We accept Cash, Checks, Debit Cards, Visa, Master Card, American Express and Discover. There is a $25.00 fee for all returned checks. Payment plans are available.

Work Comp…We will file your work comp claim provided that we have received authorization from your adjuster. NOTE: If you notify the clinic your injury is work related we will **not** file your health insurance.

Release of Information…I hereby authorize release of all information from DDSI. DDSI may disclose any or all of the patient's information for insurance claim purposes. If some other party is paying the patient's bill or by any contract may be expected to pay the bill, then DDSI may disclose any or all of the patient's information to that party to verify charges. DDSI may disclose any or all of the patient's information all health care providers who have a legitimate need for such information which indicates the presence of a communicable or venereal disease (such as Hepatitis, Syphilis, gonorrhea, Human Immunodeficiency Virus also known as A.I.D.S.) and/or presence of alcoholism, drug abuse and mental health problems.

I have read the Financial Policy of DDSI and agree to comply. I agree to treatment by the physician. In addition, I understand that I am financially responsible for services rendered by the physician and authorize my insurance company to pay benefits directly to the physician.

_____ _____

PATIENT SIGNATURE DATE

_____ _____

SIGNATURE (Spouse, Guardian, Responsible Party) DATE

Photostat of the above is as valid as the original.

Revised 8/26/14

DIGESTIVE DISEASE SPECIALISTS, INC.

OFFICE

RECEIPT OF PRIVACY NOTICE AND PATIENT RIGHTS & RESPONSIBILITIES

Patient Name (Please Print) _____ Date of Birth _____

_____ Patient Initial — I have been given a copy of the Digestive Disease Specialists, Inc. (DDSI) Privacy Notice, and understand that I may request a copy of this notice at any time.

_____ Patient Initial — I have received a copy of the Digestive Disease Specialists, Inc. Patient Rights and Responsibilities form.

_____ Patient Initial — I have received a copy of the Oklahoma State Department of Health's brochure regarding "Your Medical Treatment Rights Under Oklahoma Law"

USE AND DISCLOSURE AGREEMENT

You have the right to restrict or limit the personal health information we disclose about you to someone else, and to specify the way in which we communicate with you about your medical issues.

Please indicate your preference below:

The following people may receive information about me: **OR** I do **NOT** want you to speak with anyone else about my health issues. ☐

NAME	RELATIONSHIP

PREFERRED COMMUNICATION METHOD AND AUTHORIZATION TO LEAVE MESSAGES

☐ HOME PHONE #_____ ☐ CELL PHONE #_____ ☐ MAIL ☐ PATIENT PORTAL

☐ Yes, DDSI MAY leave a message on my answering machine/voice mail regarding my Protected Health Information.
☐ No, DDSI MAY NOT leave a message on my answering machine/voice mail regarding my Protected Health Information.

I understand that if I change my mind about any of the information on this form, I must contact Digestive Disease Specialists, Inc. to revoke this form in its entirety, or to complete a new form. Otherwise, this form will remain in effect for a period of two years.

Patient Signature _____ Today's Date _____

Digestive Disease Specialists, Inc. ***DDSI South AEC, LLC***

Advance Directive Policy

As a patient, you have the right to participate in your own health care decisions.

Digestive Disease Specialists, Inc. and DDSI South AEC, LLC recognizes these rights.

However, it is our policy that if an unexpected event occurs during your procedure, we will start CPR and EMSA will transfer you to the nearest Emergency Room for care.

When you come for a procedure, you will be asked to sign an "Agreement for Resuscitation" Form.

If you do not sign the agreement form, your procedure will need to be rescheduled at another facility.

Thank you for your cooperation.

Digestive Disease Specialists, Inc.
DDSI South AEC, L.L.C.
PATIENT HISTORY INTAKE FORM

PATIENT NAME: **Gender: F / M Age:** **DOB:** **Date:**

Marital Status: Single Married Life Partner Divorced Widow / Widower **Who lives with you?**

Occupation: **Referring Physician:**

Chief Complaint/ WHY ARE YOU HERE: **Have you been treated for this before? YES / NO**

ALLERGIES to *DRUGS / FOODS / MATERIALS:* **[ ] NO KNOWN ALLERGIES**

Females: Are you now (or could you be) pregnant?: Yes No Unknown N/A Date of LMP:

REVIEW OF SYSTEMS: **Please Answer ALL questions Yes or No to the conditions you presently have or have had in the past year.**

General	Fever	Yes / No
	Fatigue	Yes / No
	Weight loss	Yes / No
	How much have you lost?	
ENT	Eye Problems	Yes / No
	Glaucoma	Yes / No
	Hearing Difficulty	Yes / No
	Throat problems	Yes / No
	Mouth sores	Yes / No
Heart and Circulation	Chest Pain	Yes / No
	High blood pressure	Yes / No
	Congestive Heart Failure	Yes / No
	Heart Attack	
	Dates:	
	Heart Murmur	Yes / No
	Heart valve disease	Yes / No
	Heart valve replacement	Yes / No
	Type:	
	Pacemaker	Yes / No
	Type:	
	Defibrillator	Yes / No
	Date/Type:	
Lung	Asthma	Yes / No
	Emphysema / COPD	Yes / No
	Tuberculosis	Yes / No
	Shortness of Breath	Yes / No
Neuro	Seizure Disorder	Yes / No
	Stroke	Yes / No
	Dates:	
Musculo skeletal	Arthritis	Yes / No
	Back / Neck Pain	Yes / No
	Muscle / Joint Pain	Yes / No
GU	Frequent Urination	Yes / No
	Blood in Urine	Yes / No
	Kidney Stones	Yes / No
	Renal Failure	Yes / No
	Prostate Problems	Yes / No
	Menstrual Problems	Yes / No

Endo-crine	Thyroid Disease	Yes / No
	Pancreas Disease	Yes / No
	Diabetes (Insulin or Meds)	Yes / No
Hematologic/ Lymphatic	**Anemia (Low blood count)**	Yes / No
	Bleed / bruise easily	Yes / No
	Bleeding Disorders	Yes / No
	Enlarged glands	Yes / No
	HIV / AIDS	Yes / No
	Cancer	Yes / No
	Type:	
Skin	Eczema, Hives, Rash	Yes / No
Gastrointestinal / Liver	Abdominal pain / cramps	Yes / No
	Heartburn / Indigestion	Yes / No
	Bloating / Early Fullness	Yes / No
	Nausea / Vomiting	Yes / No
	Vomiting blood	Yes / No
	Loss of appetite	Yes / No
	Difficulty swallowing	Yes / No
	Stomach Ulcers	Yes / No
	Hepatitis / Type _____	Yes / No
	Cirrhosis of the Liver	Yes / No
	Jaundice	Yes / No
	Abnormal Liver Tests	Yes / No
	Change in Bowel Habits	Yes / No
	Constipation-persistent	Yes / No
	Diarrhea	Yes / No
	Black / Bloody Stools	Yes / No
	Hemorrhoids	Yes / No
	Crohn's Disease	Yes / No
	Ulcerative Colitis	Yes / No
	History of Colon Polyps	Yes / No
	Colonoscopy in past	Yes / No
	Dates:	
	EGD in past	Yes / No
	Dates:	
Mental Health	Depression	Yes / No
	Anxiety Disorder	Yes / No
	Alcoholism	Yes / No
	Substance Abuse	Yes / No

LIST ALL MEDICATIONS / SUPPLEMENTS / ASPIRIN & BLOOD THINNERS

[ ] NSAIDs - Aleve, Advil, Celebrex, Ibuprofen, Motrin, Naproxen, others - *please list*.

LIST NAME / DOSE / FREQUENCY / LAST TAKEN

[ ] See Attached List

PLEASE LIST ALL PREVIOUS MAJOR ILLNESSES / HOSPITALIZATIONS / SURGERIES AND DATES

Do you have an Advance Directive? YES / NO
If not, would you like more information about one?
YES NO

NOTES:

FAMILY HISTORY-LIST Parents (M or F),Brothers (B),Sisters (S), Children (C) **[ ] Adopted or no known family history**

Breast Cancer
Colon / Rectal Cancer
Colon Polyps
Stomach Cancer
Other GI Diseases
Crohn's Disease
Ulcerative Colitis
Ulcers
Gallstones

	Number/ Age (s) If not living age of death	Significant Diseases / Cause of Death
Mother		
Father		
Brother(s)		
Sister(s)		
Children		

SOCIAL HISTORY: Please answer ALL questions

Weight History
Present Weight
Usual Weight
Change in past year _____

Education-Completed
Grade school
High School
Vocational
College

Smoking
Pipe / Cigar / Vape / Chew--Amt? _____
Cigarettes--Packs per day? _____
Age started _____ Age quit _____
Recreational Drugs

Alcohol
Never Occasional Heavy
Amount per week?
Type / Amt per day?
Alcoholic? When did you quit?

GENERAL HEALTH *(circle response)*

Have you had the pneumonia vaccine in the past 10 years?	Yes	No
Have you traveled outside the USA in the past 3 months?	Yes	No
Have you fallen in the past year?	Yes	No

PATIENT SIGNATURE: **DATE:**