Dear _____:

You have an appointment in our _____office
on_____at_____ with_____.

Patients failing to cancel their appointments at least 24 hours in advance will be charged a $50.00 administrative fee. This fee must be paid in full prior to scheduling any future appointments.

In order to make your evaluation as complete as possible, we need the following:

1. Please bring your **insurance card** and **drivers license** with you on the day of your appointment. If your insurance requires a copay, this is due on the day of your appointment. This copay can be paid by cash, check, or credit card. **There will be a $25 billing/administrative fee for all copays that are not paid on the day of your appointment.**

2. If your insurance requires a **referral** please contact your primary care physician to make sure they have completed this. We will be happy to submit any claims to your insurance carrier but necessary referrals/authorization need to be obtained by you prior to your visit. We participate with most insurance plans but please contact your insurance company to verify we participate with your plan.

3. **Copies of medical records,** including labs, x-ray reports, and progress notes pertinent to your visit, from the physician who referred you to us. **We frequently do not receive records from referring physician and this may delay definitive medical opinion at the time of your visit due to delays in mailing, faxing, etcetera.** Please contact your referring physician to make sure they have sent records to our office.

4. Our practice utilizes an electronic medical record. In order to have your most up to date health information please complete the enclosed form and mail back to our office at least one week prior to your visit. This information will be scanned into our health information system prior to your visit and will expedite your evaluation.

The above information is integral to your evaluation, and without it your appointment may need to be rescheduled. We would like you to **arrive twenty (20) minutes** before your scheduled appointment time in order to complete preparations for your visit.

We thank you for your cooperation in advance. If you have any questions regarding these instructions, please call our office at 793-5034.

Gastroenterology Associates of Northern New York, P.C.
Five Irongate Center, Glens Falls, NY 12801

CONFIDENTIAL PATIENT INFORMATION UPDATE – **You have not been seen in our office for over one year.** – In order to help provide the best possible gastrointestinal consultation, **please complete this form prior to your upcoming visit and bring it to our office on the day of your appointment.**

Name_____ Date_____
Address_____
Home phone#_____ Work#_____Cell phone#_____
Date of Birth_____ Age_____ E-mail address_____
Referring Physician and other physicians involved in your care_____
_____

INSURANCE INFORMATION
Primary Insurance_____ Copay Amount_____
Policy holder's name_____ Policy holder's date of birth_____
Subscriber ID#_____Group #_____

Secondary Insurance_____Copay Amount_____
Policy holder's name_____Policy holder's date of birth_____
Subscriber ID#_____ Group #_____

I authorize release of any information necessary to HCFA and/or my insurance company in order to process my insurance claim. I request assignment of benefits be paid directly to my physician, and acknowledge that I am financially responsible for any unpaid balance.
Patient Signature_____ Date_____

You were last seen in our office on _____. Please update the following information:

CHIEF COMPLAINT_____

DETAILS OF PRESENT ILLNESS_____
_____

UPDATE MEDICAL HISTORY FROM LAST VISIT_____
_____

LIST ANY SURGERY SINCE LAST VISIT_____
_____

UPDATE FAMILY HISTORY_____
_____

LIST ANY SOCIAL/ENVIRONMENTAL CHANGES SINCE LAST VISIT_____
_____
MEDICATIONS:

Medication_____ Dose_____ Medication_____ Dose_____
Medication_____ Dose_____ Medication_____ Dose_____
Medication_____ Dose_____ Medication_____ Dose_____

MEDICATION ALLERGIES:_____
ARE YOU ALLERGIC TO LATEX?_____
OTHER ALLERGIES:_____

Review of Systems: Please indicate any personal history below:

Constitutional Symptoms

Good General Health Lately	no	yes
Recent weight gain	no	yes
Recent Weight loss	no	yes
Fatigue	no	yes

Eyes

Eye disease or injury	no	yes
Cataracts	no	yes
Blurred or double vision	no	yes

Ears/Nose/Mouth/Throat

Hearing loss or ringing	no	yes
Chronic sinus problems	no	yes
Nose Bleeds	no	yes
Mouth Sores	no	yes
Swollen glands in neck	no	yes
Hoarseness	no	yes

Cardiovascular

Chest pain or angina pectoris	no	yes
Palpitations	no	yes
Shortness of breath	no	yes
Swelling of feet, ankles	no	yes

Respiratory

Chronic cough	no	yes
Spitting up blood	no	yes
Wheezing	no	yes
Use oxygen at home	no	yes
Sleep Apnea	no	yes
CPAP or BiCAP at home	no	yes

Gastrointestinal

Nausea	no	yes
Vomiting	no	yes
Change in bowel movements	no	yes
Black tarry stools	no	yes
Frequent diarrhea	no	yes
Constipation	no	yes
Rectal Bleeding	no	yes
Abdominal Pain	no	yes
Loss of appetite	no	yes
Heartburn	no	yes
Swallowing difficulties	no	yes
Bloating	no	yes
Dairy product intolerance	no	yes
Fatty food intolerance	no	yes

Genitourinary

Frequent urination	no	yes
Burning or painful urination	no	yes
Blood/air in urine	no	yes
Incontinence or dribbling	no	yes
Kidney stones	no	yes
Are you pregnant now	no	yes
Heavy Periods	no	yes

Musculoskeletal

Joint Pain	no	yes
Stiffness or swelling	no	yes
Muscle Cramps, weakness	no	yes
Back Pain	no	yes
Cold extremities	no	yes
Difficulty in walking	no	yes

Neurologic

Headaches	no	yes
Tremors	no	yes
Paralysis	no	yes
Head injury	no	yes
Lightheaded or dizzy	no	yes
Convulsions or seizures	no	yes

Psychiatric

Memory loss or confusion	no	yes
Nervousness/anxiety	no	yes
Depression	no	yes
Insomnia	no	yes

Endocrine

Thyroid Problems	no	yes
Heat or cold intolerance	no	yes
Skin becoming dryer	no	yes

Hematologic/Lymphatic

Bleeding or bruising tendency	no	yes
Phlebitis	no	yes

Integumentary (skin)

Rash or itching	no	yes
Jaundice	no	yes
Tattoos	no	yes
Change in hair or nails	no	yes

Other

_____

_____

_____

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 doctor's office of any changes in my medical status.

_____ _____

Signature of Patient, Parent, or Guardian Date Signature of Physician Date

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