PATIENT REGISTRATION FORM

Date of appointment: _____

Patient Name: _____ Age: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone-Home: _____ Work: _____ Cell: _____

Email address: _____

(Sex) M F Social Security: _____ Marital Status: S M D W SEP

Name & Address of PCP: _____
PCP Phone#: _____

Primary Language: _____
Race: *Please select one*

☐ American Indian or Alaska Native ☐ White ☐ Asian
☐ Black or African American ☐ Hispanic ☐ Native Hawaiian
☐ Other Race: _____ ☐ Refuse to Report

Ethnicity: *Please select one* ☐ Hispanic ☐ Non-Hispanic ☐ Refuse to Report

Emergency Contact: _____ Relationship: _____
Address: _____ Phone#: _____

Patient's Employment Status: Full Time Part Time Student
Patient's Employer: _____ **Name of School:** _____
Employer's address: _____ City: _____

Primary Insurance Carrier:
Insurance Company: _____ Member ID#: _____ Grp#: _____
Insured's Name (if different from patient): _____ Insured's SS#: _____
Insured's Employer: _____ Insured's DOB: _____
Patient's relationship to insured: SELF SPOUSE DEPENDENT

Secondary Insurance Carrier
Insurance Company: _____ Member ID#: _____ Grp#: _____
Insured's Employer: _____ Insured's SS#: _____
Patient's relationship to insured: SELF SPOUSE DEPENDENT
Spouse Name: _____ Spouse DOB: _____

Pharmacy Name and Phone#: _____
How did you hear about our services? _____

Gastro Health

Acknowledgement of Privacy Notice and Contact Information With my signature below:

- I acknowledge that I have received a copy of Gastro Health Notice of Privacy Practices which explains the use and disclosure of my protected health information.
- I understand that HIPAA law allows Gastro Health to call my home or other designated location and leave a message on an answering machine or cell phone voice mail in reference to any items that assist the practice in carrying out Treatment, Payment, and Healthcare Operations (TPO), such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.
- Gastro Health may mail to my home or designated location any items that assist the practice in carrying out TPO such as appointment reminders and patient statements.
- Gastro Health staff will leave medical information pertaining to my care at the following phone number(s). I will notify the practice whenever this information changes:

Home Telephone Number _____-_____-_____
Work Telephone Number _____-_____-_____
Cell Phone/Voice Mail _____-_____-_____

Signature: _____ DOB: _____ Date: _____

I understand that HIPAA law allows Gastro Health speak with my family, friends, or others regarding my treatment and/or payment if in the professional judgment of the physician doing so is in my best interests.

___ **I do not object** to share and discuss my health information with family, friends, or others (clergy, employer, or state agency) if in the professional judgment of the physician doing so is in my best interests.

___ **I do object** to the sharing of my health information with family, friends, or others as allowed by HIPAA law. However, if necessary to serve my best interests, you may share and discuss my information with the following person(s):

Name	Phone Number	Relation

I understand that my insurance carrier may not cover all service and that I agree to be responsible for all payment of all such services rendered on my behalf. If I do not sign below accep ting payment responsibility, Gastro Health may decline to provide treatment to me.

Signature of Patient: _____ Date: _____

INABLILITY TO OBTAIN ACKNOWLEDGEMENT

If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain this acknowledgement and the reason why acknowledgment was not obtained.

_____

Signature of Office Staff: _____ Date: _____

CONSENT FOR RX HUB INQUIRY

I herby provide my consent for the Practice of Gastro Health to obtain my Rx History using the SureScripts-RxHub network. I understand that this inquiry will provide my physician with an accounting of my medication history reported by Pharmacy Benefit Managers and retail pharmacies. I also understand that SureScripts-Rx Hub has certified that Rx History Capture follows strict protocols to align with HIPAA requirements and respect patient privacy. All queries and responses are made automatically through secure system-to-system communications.

Signed: _____ Date: _____

PATIENT HISTORY

Name: _____ **Age:** _____ **DOB:** _____ **Date:** _____

Doctor who referred you: **Other doctors you have:**

What is your main symptom, complaint, or reason for this appointment?

Circle other medical problems that YOU have had:

Heart attacked/angina	Heart failure	Abnormal heat rhythm
Heart valve surgery or murmur	Rheumatic Fever	High blood pressure
Diabetes	Thyroid problem	High cholesterol/triglycerides
Asthma/bronchitis/emphysema	Ulcer	Diverticulitis
Colitis or Crohn's Disease	Hepatitis	Pancreatitis
Gallbladder disease	Tuberculosis	Arthritis
Cancer of _____	Radiation treatment	Seizure
Kidney Disease	Prostate problem	Depression/anxiety
Stroke	Operations (include year performed):	

Write down which of the above conditions have occurred in your family:

Has anyone in your family ever had colon cancer or colon polyps?

List your medicines with dosage and frequency (include all "over-the-counter" medicines):

Are you allergic to any medicines? **YES NO** **List these medications:**

Patient Name: _____ DOB: _____

Circle symptoms you are having or circle "NONE"

General: Weight Loss Weakness Fever NONE

Cardiac: Chest Pain Palpitations Ankle swelling Shortness of breath Fainting NONE

Respiratory: Cough Excessive phlegm or sputum Coughing up blood Wheezing NONE

Urinary Tract: Frequent urination Burning Bloody or brown urine Slow urination NONE

GYN/Breast: Breast pain, lump or discharge Abnormal vaginal discharge or bleeding NONE

Skin: Rash Itching Hair loss NONE

Joints: Pain Swelling Stiffness NONE

Lymph Glands: Swollen glands Easy bruising Frequent bloody nose or gums NONE

Endocrine: Excessive thirst Excessive urination Voice change
Always feeling too cold or too hot Shakiness NONE

Neurologic: Frequent headaches Seizures Double vision Weakness of hand or leg
Numbness-where? NONE

Gastrointestinal: Abdominal pain Nausea/vomiting Heartburn Trouble swallowing
Constipation Diarrhea Blood in stool Black stool
Abdominal swelling Poor appetite Jaundice Hernia NONE

Have you ever smoked tobacco? _____ For how long? _____ Do you still smoke?_____

Do you drink alcohol? YES NO **How much per week?** _____

Describe your current occupation: _____

Former occupation: _____

Describe your current household (who lives with you or who can help you if you live alone):

(For physician use only): Date reviewed: _____ _____ _____ _____

Doctors affiliated with Beth Israel Deaconess Medical Center (BIDMC) and other doctors who participate in the Beth Israel Deaconess Care Organization (BIDCO) participate in a **Health Information Exchange (HIE).** The HIE is a secure computer network that, with my permission, will allow my BIDMC and BIDCO providers to view all of my health information (medical records). The HIE protects the confidentiality, privacy and security of the information. By making my health information available electronically, my BIDMC and BIDCO providers will be able to better coordinate my care. By signing this form, I give my permission to my BIDMC and BIDCO providers to view my health information electronically via the HIE.

I understand that my health information may contain (now or in the future) certain types of sensitive information:

- HIV/AIDS status
- genetic testing
- treatment for substance abuse (alcohol or drug)
- venereal disease(s)
- mammography records
- family planning services
- confidential communications with a psychotherapist, psychologist, social worker, sexual assault counselor, domestic violence counselor or other allied mental health professional or human services professional
- if I am an emancipated minor, information about my treatment and diagnosis (but not shared with my parents)

By signing this form, I agree to the release of *all* my health information, including sensitive information, to my BIDMC and BIDCO providers through the HIE.

If you do not wish for sensitive information to be released in connection with the HIE, please do not sign this consent.

I understand that BIDMC, BIDCO, and my health care provider have taken reasonable steps to protect my confidentiality.

This Authorization will stay in effect from the date of my signature below until my provider is no longer participating in the HIE. I have the right to take back my consent (revocation), in writing, at any time. My revocation will be effective when my provider receives it. I may also contact my provider's Privacy Officer by mail at [insert address], by telephone at [insert number] or by email at [insert email address].

I have read this Authorization form and I understand what it says. All of my questions have been answered in a language that I understand. I agree with the information on this form. By signing this form I authorize my health care provider to use or disclose my health information in order to participate in the HIE.

_____ _____

Signature of Patient Date

_____ _____

Patient Printed Name DOB

If the patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

_____ _____ _____

Signature of Authorized Personal Representative | Relationship to Patient | Date