Midwest Gastrointestinal Associates PC

Welcome to Midwest Gastrointestinal Associates, PC

Dear Patient:

An appointment has been scheduled for you on _____

with Doctor_____ at

8901 Indian Hills Drive, Suite 200
Omaha, NE 68114
Phone (402) 397-7057
Fax (402) 397-6656

Our building has white pillars with black windows and is located on the south side of Indian Hills Drive (map on reverse).

Please arrive for your appointment at _____ am/pm.

Your appointment is scheduled at _____ am/pm.

In an effort to make the registration process more efficient, please bring the following items to your appointment:

- Completed Midwest GI History Form (enclosed). This form contains valuable information and will assist the doctor in your care.
- Your insurance card(s) and photo ID.
- A list of your medications (to include prescription and over-the-counter), vitamins, supplements and herbs along with the dosage, and how often you take them.
- Signed Midwest GI Financial Policy (enclosed). It is important to us that you understand our policy so please read this carefully and if you have questions, do not hesitate to ask.
- Co-pay is expected to be paid at the time of service.

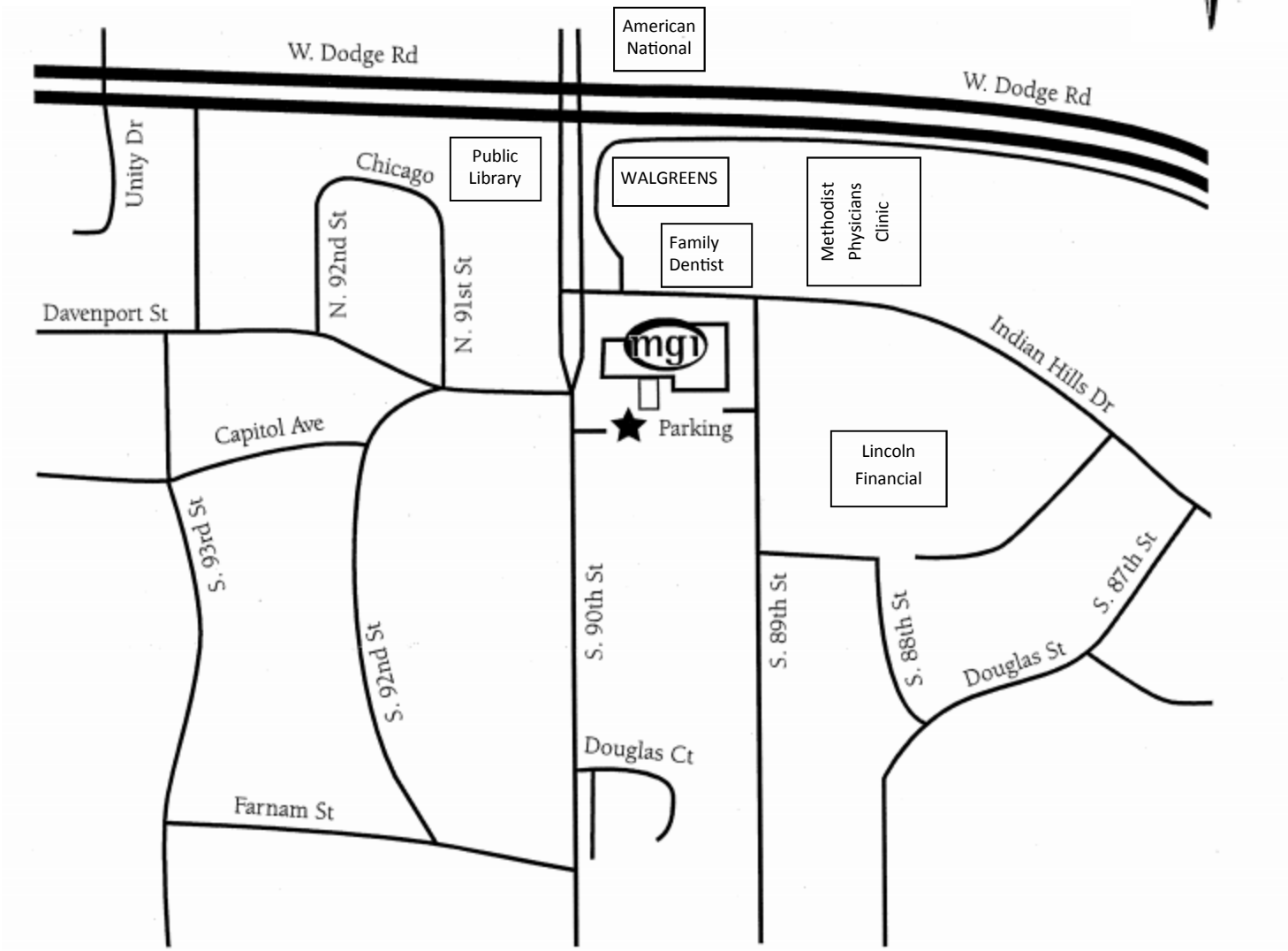
Again we would like to welcome you to Midwest Gastrointestinal Associates, PC.

Sincerely,

Midwest Gastrointestinal Associates, PC

Midwest Gastrointestinal Associates PC

8901 Indian Hills Drive, Suite 200
Omaha, NE 68114
402-397-7057



North Side of Building

South Side of Building

Midwest Gastrointestinal Associates, PC
History Form
Please complete this form in full prior to your visit

NAME: _____ **DOB:** _____

DATE: _____ **AGE:** _____ **SEX: M / F** **Primary Care Provider:** _____

ALLERGIES TO MEDICATIONS: _____

CURRENT MEDICAL PROBLEM

Briefly describe why you came to our clinic today: _____

CURRENT MEDICATIONS:

PRESCRIPTION MEDICATION NAME, DOSE (mg/units), FREQUENCY	**PRESCRIPTION MEDICATION NAME, DOSE (mg/units), FREQUENCY**

DO YOU TAKE ANY OVER THE COUNTER MEDICATIONS OR SUPPLEMENTS (Such as Aspirin, Ibuprofen, Alka-Seltzer, Metamucil):

OVER COUNTER MED/SUPPLEMMENT NAME, DOSE (mg/units), FREQUENCY	**OVER COUNTER MED/SUPPLEMMENT NAME, DOSE (mg/units), FREQUENCY**

MEDICAL HISTORY
Do you have or have you ever had (check all that apply):

General

YES NO
- ☐ ☐ Loss of appetite
- ☐ ☐ Weight loss
- ☐ ☐ Increased fatigue

Chest

YES NO
- ☐ ☐ Heartburn
- ☐ ☐ Indigestion
- ☐ ☐ Chest pain
- ☐ ☐ Belching
- ☐ ☐ Regurgitation of foods or liquids
- ☐ ☐ Chest / Abdominal pain awakens you at night

Mouth-Esophageal

YES NO
- ☐ ☐ Sore throat / burning
- ☐ ☐ Difficulty swallowing pills or food
- ☐ ☐ Difficulty swallowing liquids

Abdomen

YES NO
- ☐ ☐ Nausea
- ☐ ☐ Vomiting
- ☐ ☐ Abdominal pain
- ☐ ☐ Abdominal pain associated with meals
- ☐ ☐ Bloating / Gas
- ☐ ☐ Milk / Lactose intolerance
- ☐ ☐ Ulcers
- ☐ ☐ Vomiting blood

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Bowel Habits

YES	NO	
☐	☐	A change in your bowel habits
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Alternate between constipation and diarrhea
☐	☐	Feeling of bowels not emptying completely
☐	☐	A sense of urgency to empty your bowels

Colon / Rectal

YES	NO	
☐	☐	Abdominal pain in lower abdomen
☐	☐	Rectal pain
☐	☐	Rectal bleeding
☐	☐	Black or tarry looking stools
☐	☐	Mucus or pus in stools
☐	☐	Abdominal pain relieved by a bowel movement
☐	☐	Increased rectal gas

Digestive System

YES	NO	
☐	☐	Reflux
☐	☐	Esophageal stricture
☐	☐	Stomach ulcers
☐	☐	Hiatal Hernia
☐	☐	Gallbladder problems
☐	☐	Pancreas problems
☐	☐	Diverticulosis
☐	☐	Diverticulitis
☐	☐	Liver problems
☐	☐	Gallstones
☐	☐	Jaundice (yellow eyes/skin)
☐	☐	Vomiting blood
☐	☐	Inflammatory Bowel Disease/Crohn's/Ulcerative Colitis
☐	☐	Colon Cancer
☐	☐	Anal fissures
☐	☐	Anal fistula
☐	☐	Colon polyp
☐	☐	Hemorrhoids
☐	☐	Hepatitis
☐	☐	Irritable Bowel Syndrome
☐	☐	Peptic ulcers
☐	☐	Other GI diseases not mentioned

General

YES	NO	
☐	☐	Fever or chills
☐	☐	Hot flashes
☐	☐	Problems sleeping/sleep apnea/nasal C-Pap
☐	☐	Weight loss in past year
☐	☐	Weight gain in past year
☐	☐	Night sweats
☐	☐	Fatigue
☐	☐	Change in appetite

Skin

YES	NO	
☐	☐	Changes in skin color
☐	☐	Abnormalities of the skin
☐	☐	Unusual itching of the skin
☐	☐	Skin rashes

Respiratory

YES	NO	
☐	☐	Wheezing
☐	☐	Chronic cough
☐	☐	Coughing up blood or sputum
☐	☐	Lung disease
☐	☐	Tuberculosis
☐	☐	Positive skin test for TB
☐	☐	Shortness of breath
☐	☐	Bronchitis
☐	☐	Pneumonia
☐	☐	Asthma

Genitourinary

YES	NO	
☐	☐	Prostate problems (male)
☐	☐	Get up at night to urinate
☐	☐	Frequent urination
☐	☐	Painful urination
☐	☐	Blood in urine
☐	☐	Kidney stones
☐	☐	Kidney disease

Musculoskeletal

YES	NO	
☐	☐	Neck or back pain
☐	☐	Joint pain
☐	☐	Joint replacement
☐	☐	Muscle aches or tenderness
☐	☐	Osteoporosis/Arthritis
☐	☐	Swelling joints

Neurological

YES	NO	
☐	☐	Frequent headaches
☐	☐	Seizures
☐	☐	Stroke
☐	☐	Trauma

Psychiatric

YES	NO	
☐	☐	Problems with anxiety
☐	☐	Depression
☐	☐	Insomnia/trouble sleeping
☐	☐	Drug/Alcohol abuse
☐	☐	Stress (at home or work)
☐	☐	Other psychiatric problems

Eyes, Ears, Nose, Throat, Mouth

YES	NO	
☐	☐	Eye injuries or diseases
☐	☐	Ear diseases
☐	☐	Sinus problems
☐	☐	Chronic sore throat
☐	☐	Mouth ulcers / sores
☐	☐	Nosebleeds
☐	☐	Hoarseness

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NAME: _____ **DATE OF BIRTH:** _____

Cardiovascular

YES	NO	
☐	☐	Dizziness
☐	☐	Shortness of breath
☐	☐	Fainting spells or blackout spells
☐	☐	Swelling of the feet or ankles
☐	☐	Chest pain or tightness
☐	☐	High blood pressure
☐	☐	Heart disease
☐	☐	Rheumatic fever
☐	☐	Artificial heart valve
☐	☐	Blood thinners
☐	☐	High cholesterol
☐	☐	Rapid or irregular heartbeat
☐	☐	Valvular disease
☐	☐	Heart murmurs
☐	☐	Coronary artery disease

Endocrine

YES	NO	
☐	☐	Diabetes
☐	☐	Thyroid disease

Hematology / Lymphatic

YES	NO	
☐	☐	Lymph node enlargement
☐	☐	Anemia
☐	☐	Bleeding problems
☐	☐	Cancer
☐	☐	Excessive bruising
☐	☐	Ever had a blood transfusion

Gynecological

YES	NO	
☐	☐	Painful periods
☐	☐	Regular periods
☐	☐	Discharge or pain
☐	☐	Endometriosis
☐	☐	Ovarian cysts
☐	☐	Currently sexually active
☐	☐	History of Gonorrhea, Chlamydia, Syphilis

Date of last pelvic exam: _____

Last menstrual period: _____

Date of onset of menopause: _____

Number of pregnancies & children: _____

DIETARY:

Do you follow a special diet? ☐ No ☐ Yes If yes, explain: _____

Do you have a desire to lose weight? ☐ No ☐ Yes If yes, how much: _____

Do you have a eating disorder? ☐ No ☐ Yes If yes, explain: _____

HAVE YOU EVER HAD AN OPERATION:

Date	Where	Type of operation and reason	Physician

HAVE YOU EVER BEEN IN THE HOSPITAL:

Date	Where	Reason for hospital admission	Physician

Have you been seen by a Gastroenterologist before? Yes ____ No ____ Procedures Performed? _____

Name of MD/DO: _____ Dates: _____

Prior colorectal cancer screening : Yes ____ No ____ Location: _____

Results: _____

Last Colonoscopy: _____ Last Upper Endoscopy: _____

Recent X-Rays: _____ Where/When: _____

Recent Blood Work: _____ Where/When: _____

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FAMILY HISTORY (check all that apply):

If answered Yes, please indicate family member (GM=Grandmother, GF= Grandfather, M=Mother, F=Father, B=Brother, S=Sister, U=Unknown, O=Other)

YES	NO		Who	YES	NO		Who
☐	☐	Colon Cancer	_____	☐	☐	Heart Disease	_____
☐	☐	Colon polyps	_____	☐	☐	Stroke	_____
☐	☐	Pancreatic Cancer	_____	☐	☐	High blood pressure	_____
☐	☐	Pancreatitis	_____	☐	☐	Lung Disease	_____
☐	☐	Crohn's Disease	_____	☐	☐	Kidney Disease	_____
☐	☐	Ulcerative colitis	_____	☐	☐	Tuberculosis (TB)	_____
☐	☐	Other colitis	_____	☐	☐	Peptic ulcers	_____
☐	☐	Osteoporosis	_____	☐	☐	Gallstones	_____
☐	☐	Seizure	_____	☐	☐	Cirrhosis	_____
☐	☐	Celiac Sprue	_____	☐	☐	Liver Disease	_____
☐	☐	Ulcer	_____	☐	☐	Diabetes	_____
☐	☐	Bleeding	_____	☐	☐	Other digestive diseases	_____
☐	☐	Alcoholism	_____	☐	☐	Any other diseases run in several family members	_____
☐	☐	Thyroid disease	_____	☐	☐	Cancer: Type _____	_____
☐	☐	Hemochromatosis (excess iron)	_____				

SOCIAL HISTORY(check all that apply):

☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Current occupation: _____ ☐ Unemployed ☐ Retired ☐ Disabled

Education Level: (check highest level completed)

☐ Attended High School, non-graduate ☐ High School Graduate / GED

☐ Tech/Trade ☐ Some College ☐ College Graduate

Stress Level: ☐ Low ☐ Average ☐ High

Have you ever lived or traveled outside the United States? ☐ No ☐ Yes, where: _____

Any illness associated with travel? ☐ No ☐ Yes

Do you exercise? ☐ None ☐ Occasionally ☐ Regularly

Have you ever experienced abuse? ☐ No ☐ Yes If yes, what type? ☐ Physical ☐ Emotional ☐ Sexual

Tobacco Use:	☐ Use Everyday	☐ Use Some Days	☐ Used Formerly	☐ Never Used
Alcohol Use:	☐ Use Everyday	☐ Use Some Days	☐ Used Formerly	☐ Never Used
Recreational Drugs:	☐ Use Everyday	☐ Use Some Days	☐ Used Formerly	☐ Never Used
Caffeine:	☐ Use Everyday	☐ Use Some Days	☐ Used Formerly	☐ Never Used

MIDWEST GASTROINTESTINAL ASSOCIATES, P.C.
FINANCIAL POLICY

We would like to take the opportunity to welcome you to our facility and to let you know that we are committed to providing you the best possible care. Thanks in advance for reading this information as it's critical that you understand our Financial Policy. We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

We are here to assist you in providing information to your Health Insurance Company so that payment may be made according to the coverage you have purchased. Please keep in mind that not all services are a covered benefit in all Plans and that your insurance coverage is an agreement between you and your Health Insurance Company. Payment for services at Midwest Gastrointestinal Associates, P.C., is ultimately the patient's responsibility.

If you are scheduled for a screening colonoscopy: The Facility submits procedural documentation and charges according to Centers for Medicare and Medicaid Services and American Medical Association guidelines and is not responsible for determining how your benefits will be paid by your insurance plan. Please keep in mind that all charges may not be covered under your screening and health preventive benefits. If you have questions please call us at (402) 504-3846 for a more detailed explanation.

Providing you have insurance, we will file your primary and secondary insurance for you as a courtesy, provided we have your assignment of benefits as well as a copy of your insurance card(s) identifying your primary and secondary coverage if applicable.

If your Insurance Plan requires an authorization for care or treatment, it is the patient's responsibility to obtain one prior to your visit. Contact your Insurance Carrier if you are not sure. If a referral is not obtained, your insurance company may deny payment coverage and could result in patient responsibility.

Patient deductibles, coinsurance and co-payment amounts are established by your Health Plan and are your responsibility. You will be contacted prior to your appointment to review your insurance benefits and discuss payment arrangements for your deductibles and coinsurance.

Prompt payment of your account is expected; however, we realize that situations may arise whereby you may have difficulty meeting your obligation. If such problems do arise, we encourage you to contact us for assistance in the management of your account. We do use outside agencies as a means of collection should your account become delinquent.

Patients who fail to provide insurance information are directly responsible for payment of their account.

If you don't have insurance, acceptable financial arrangements will need to be determined prior to the date of service. An account representative will be happy to assist you and can be reached at (402) 397-7057. Please note a deposit will be required at the time of visit.

You will be billed a professional fee for the services provided by the physician's of Midwest Gastrointestinal Associates, P.C. You may also receive a bill for facility fees in the event you have a procedure done outside the offices of Midwest Gastrointestinal Associates, P.C. In addition, if lab work is necessary you may receive a separate billing for those services.

For your convenience, checks, cash, Visa, MasterCard, Discover, American Express and debit cards are accepted.

AUTHORIZATION

I have read and agree to the terms and conditions listed above and I hereby authorize the release of any medical information necessary to process my health insurance claim and request payment of benefits to Midwest Gastrointestinal Associates, P.C. I understand I am financially responsible to Midwest Gastrointestinal Associates, P.C. for charges not covered or denied by my insurance company. A photocopy of this agreement shall be valid as the original. This authorization is to remain in effect until revoked in writing by me or my legal representation.

_____ _____

Signature Date