



## Welcome to Midwest Gastrointestinal Associates, PC

Dear Patient:

An appointment has been scheduled for you on \_\_\_\_\_

with Doctor \_\_\_\_\_ at

717 North 190th Plaza, Suite 3200

Omaha, NE 68022

(map on reverse)

Phone (402) 397-7057

Fax (402) 397-6656

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

# Methodist Physicians Clinic - 192 Dodge Primary Care CAMPUS MAP

MGI's office is located in the Medical Office Building, 717 North 190th Plaza, Suite 3200. Please park in Lot #3 and enter building on West side. We are located on the 3<sup>rd</sup> floor.



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

**Mouth-Esophageal**

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

**Chest**

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

**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                       |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | A change in your bowel habits               |
| <input type="checkbox"/> | <input type="checkbox"/> | Constipation                                |
| <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Alternate between constipation and diarrhea |
| <input type="checkbox"/> | <input type="checkbox"/> | Feeling of bowels not emptying completely   |
| <input type="checkbox"/> | <input type="checkbox"/> | A sense of urgency to empty your bowels     |

**Colon / Rectal**

- | YES                      | NO                       |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Abdominal pain in lower abdomen             |
| <input type="checkbox"/> | <input type="checkbox"/> | Rectal pain                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Rectal bleeding                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Black or tarry looking stools               |
| <input type="checkbox"/> | <input type="checkbox"/> | Mucus or pus in stools                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Abdominal pain relieved by a bowel movement |
| <input type="checkbox"/> | <input type="checkbox"/> | Increased rectal gas                        |

**Digestive System**

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

**General**

- | YES                      | NO                       |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Fever or chills                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Hot flashes                               |
| <input type="checkbox"/> | <input type="checkbox"/> | Problems sleeping/sleep apnea/nasal C-Pap |
| <input type="checkbox"/> | <input type="checkbox"/> | Weight loss in past year                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Weight gain in past year                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Night sweats                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Fatigue                                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Change in appetite                        |

**Skin**

- | YES                      | NO                       |                             |
|--------------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Changes in skin color       |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormalities of the skin   |
| <input type="checkbox"/> | <input type="checkbox"/> | Unusual itching of the skin |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin rashes                 |

**Respiratory**

- | YES                      | NO                       |                             |
|--------------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Wheezing                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic cough               |
| <input type="checkbox"/> | <input type="checkbox"/> | Coughing up blood or sputum |
| <input type="checkbox"/> | <input type="checkbox"/> | Lung disease                |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis                |
| <input type="checkbox"/> | <input type="checkbox"/> | Positive skin test for TB   |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath         |
| <input type="checkbox"/> | <input type="checkbox"/> | Bronchitis                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Pneumonia                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma                      |

**Genitourinary**

- | YES                      | NO                       |                            |
|--------------------------|--------------------------|----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Prostate problems (male)   |
| <input type="checkbox"/> | <input type="checkbox"/> | Get up at night to urinate |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent urination         |
| <input type="checkbox"/> | <input type="checkbox"/> | Painful urination          |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood in urine             |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney stones              |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney disease             |

**Musculoskeletal**

- | YES                      | NO                       |                            |
|--------------------------|--------------------------|----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Neck or back pain          |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint pain                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint replacement          |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscle aches or tenderness |
| <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis/Arthritis     |
| <input type="checkbox"/> | <input type="checkbox"/> | Swelling joints            |

**Neurological**

- | YES                      | NO                       |                    |
|--------------------------|--------------------------|--------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures           |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke             |
| <input type="checkbox"/> | <input type="checkbox"/> | Trauma             |

**Psychiatric**

- | YES                      | NO                       |                            |
|--------------------------|--------------------------|----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Problems with anxiety      |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Insomnia/trouble sleeping  |
| <input type="checkbox"/> | <input type="checkbox"/> | Drug/Alcohol abuse         |
| <input type="checkbox"/> | <input type="checkbox"/> | Stress (at home or work)   |
| <input type="checkbox"/> | <input type="checkbox"/> | Other psychiatric problems |

**Eyes, Ears, Nose, Throat, Mouth**

- | YES                      | NO                       |                          |
|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Eye injuries or diseases |
| <input type="checkbox"/> | <input type="checkbox"/> | Ear diseases             |
| <input type="checkbox"/> | <input type="checkbox"/> | Sinus problems           |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic sore throat      |
| <input type="checkbox"/> | <input type="checkbox"/> | Mouth ulcers / sores     |
| <input type="checkbox"/> | <input type="checkbox"/> | Nosebleeds               |
| <input type="checkbox"/> | <input type="checkbox"/> | 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 an 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		
<input type="checkbox"/>	<input type="checkbox"/>	Colon Cancer	_____	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	_____
<input type="checkbox"/>	<input type="checkbox"/>	Colon polyps	_____	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	_____
<input type="checkbox"/>	<input type="checkbox"/>	Pancreatic Cancer	_____	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	_____
<input type="checkbox"/>	<input type="checkbox"/>	Pancreatitis	_____	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	_____
<input type="checkbox"/>	<input type="checkbox"/>	Crohn's Disease	_____	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	_____
<input type="checkbox"/>	<input type="checkbox"/>	Ulcerative colitis	_____	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis (TB)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other colitis	_____	<input type="checkbox"/>	<input type="checkbox"/>	Peptic ulcers	_____
<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	_____	<input type="checkbox"/>	<input type="checkbox"/>	Gallstones	_____
<input type="checkbox"/>	<input type="checkbox"/>	Seizure	_____	<input type="checkbox"/>	<input type="checkbox"/>	Cirrhosis	_____
<input type="checkbox"/>	<input type="checkbox"/>	Celiac Sprue	_____	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	_____
<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	_____	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	_____
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding	_____	<input type="checkbox"/>	<input type="checkbox"/>	Other digestive diseases	_____
<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	_____	<input type="checkbox"/>	<input type="checkbox"/>	Any other diseases run in several family members	_____
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	_____	<input type="checkbox"/>	<input type="checkbox"/>	Cancer: Type _____	_____
<input type="checkbox"/>	<input type="checkbox"/>	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