PATIENT REGISTRATION FORM (eCW)

PATIENT INFORMATION (Please print)

Patient's Legal Name: (Last)_____(First)_____(MI) _____

Preferred Full Name (if different from above): _____

Address: _____

City, State, Zip: _____

Home Phone Number (landline):_____Cell:_____Work: _____

E-Mail Address:_____Date of Birth: _____

Gender Identity: ☐ Female ☐ Male ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer ☐ Choose not to disclose
☐ Additional Gender category not listed _____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White
☐ Hispanic ☐ Chose not to disclose ☐ Other not listed _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Choose not to disclose

Preferred Language: ☐ English ☐ Spanish ☐ ASL ☐ Japanese ☐ Mandarin ☐ Korean ☐ French ☐ Indian: Hindi, Tamil, Gujarati etc
☐ Swahili ☐ Russian ☐ Arabic ☐ Vietnamese ☐ Haitian Creole ☐ Bosnian/Croatian/Serbian/Serbo-Croatian
☐ Albanian ☐ Burmese ☐ Tagalog ☐ Farsi-Iranian/Persian ☐ Portuguese ☐ Cambodian ☐ Other not listed_____

Patient Social Security Number:___-_____-_____

RESPONSIBLE PARTY INFORMATION (*If not self*) (Information used for patient balance statements)

Responsible party: ☐ Another patient ☐ Guarantor ☐ Self Check here if address and telephone information is same as patient ☐
Responsible party name: (Last)_____(First)_____(MI) _____
Date of birth: MM_____/DD_____/YYYY_____ Sex: ☐ Female ☐ Male
Responsible Party Social Security Number:___-_____-_____Phone number: _____
Address:_____
City, State:_____ZIP: _____

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last)_____ (First) _____
Phone number:_____ Do you have a living will? ☐ Yes ☐ No
Emergency contact relationship to patient:_____ ☐ Guardian
Address_____
City, State:_____ZIP: _____
Home phone:_____Work hone:_____Ext. _____

GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).
I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative:_____Date: _____

Printed name of patient or personal representative:_____Relationship to patient: _____

Patient Name _____ Date of Birth _____ Today's Date _____

Pediatric Gastroenterology Associates of Houston
New Patient Questionnaire

Birth History

What hospital/birth center? _____

C-section or vaginal delivery? ◯ c-section ◯ vaginal

What was the birth weight? _____

What was the baby's gestational age at birth? _____

How long was the baby in the hospital? _____

Please list any problems/complications:

Past Medical History

Please list the patient's current medical problems: ☐ None

Please list all surgeries in the patient's lifetime: ☐ None

Surgery:	Date:	Surgeon:

Please list the patient's current medications (if additional room is needed, please provide attached list): ☐ None

Name: ☐ See attached.	Frequency/Dose/Strength:

Please list any allergies (medication, food, other): ☐ None

Please list any other medical specialists the patient has seen (ENT, allergist, cardiologist, etc.)

How many days of school did the patient miss in the last year for illness?

What is the name of your current home health care company?

Please list any special home medical equipment (oxygen, feeding pump, apnea monitor, etc.)

Family History

Please list the patient's siblings: ☐ None

Name:	Birth Date:	Gender:
		◯ M ◯ F
		◯ M ◯ F
		◯ M ◯ F
		◯ M ◯ F
		◯ M ◯ F

Does any one in the family have any of the following conditions (please check all that apply):

☐ Crohn's Disease ☐ Ulcerative Colitis ☐ Lupus
☐ Rheumatoid Arthritis ☐ Stomach Ulcers ☐ Celiac Disease
☐ Congenital Disease ☐ Type I Diabetes ☐ Migraines

Social History

Does patient attend any type of daycare? ☐ Yes ☐ No

Does anyone the patient knows smoke? ☐ Yes ☐ No

Please list any pets in the home, or other animals to which the patient is exposed. ☐ None

Who lives with the patient at home?

What grade is the patient currently in?

Patient Name _____ Date of Birth _____ Today's Date _____

Has the patient recently traveled? ☐ No
If so, where and when?

Has the patient eaten foreign foods or unpasteurized dairy products? If so, what and when? ☐ No

Review of Systems

Constitutional

Fever or chills (recent, or recurrent)	☐ Yes	☐ No
Night sweats	☐ Yes	☐ No
Weight ◯ loss or ◯ gain	☐ Yes	☐ No
Decreased energy	☐ Yes	☐ No
Appetite changes	☐ Yes	☐ No
Difficulty gaining weight	☐ Yes	☐ No
Difficulty sleeping	☐ Yes	☐ No

Eye

Vision Problems	☐ Yes	☐ No
Yellow eyes	☐ Yes	☐ No

Skin

Jaundice	☐ Yes	☐ No
Rash	☐ Yes	☐ No

Neurological

Frequent headaches	☐ Yes	☐ No
Convulsions or seizures	☐ Yes	☐ No
Developmental delays	☐ Yes	☐ No
Is or was your child enrolled in ECI	☐ Yes	☐ No
Does your child require special classes in school	☐ Yes	☐ No
Does your child require therapy	☐ Yes	☐ No

If yes, please identify
◯ Speech ◯ Language ◯ Physical ◯ Occupational

Cardiovascular

Heart murmur or heart problem	☐ Yes	☐ No
Chest pain	☐ Yes	☐ No
Exercise limitation	☐ Yes	☐ No
Fainting Spells	☐ Yes	☐ No

Gastrointestinal

Diarrhea	☐ Yes	☐ No
Difficulty swallowing	☐ Yes	☐ No
Vomiting or excessive spit up	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Heart burn	☐ Yes	☐ No
Frequent abdominal pain	☐ Yes	☐ No
History of iron or other nutritional deficiency	☐ Yes	☐ No
Mouth sores	☐ Yes	☐ No
Blood in stools	☐ Yes	☐ No
White stools	☐ Yes	☐ No

Allergic/Immunologic

Eczema (dry, rough, or itchy skin)	☐ Yes	☐ No
Hives (urticaria)	☐ Yes	☐ No
Allergies (allergic rhinitis, hay fever, etc.)	☐ Yes	☐ No

Endocrine

Too hot or too cold	☐ Yes	☐ No
Blood sugar problems (including diabetes)	☐ Yes	☐ No
Easy bruising / bleeding	☐ Yes	☐ No
Take birth control pills	☐ Yes	☐ No

Psychiatric

Symptoms of anxiety (excessive worries)	☐ Yes	☐ No
Symptoms of depression (hopeless, helpless, excessive sadness, crying)	☐ Yes	☐ No
Behavioral problems (fighting at school)	☐ Yes	☐ No
Other psychiatric conditions	☐ Yes	☐ No

Musculoskeletal

Joint pain or swelling	☐ Yes	☐ No
Muscle weakness	☐ Yes	☐ No

Other

Please note any other important symptoms not listed above:

_____

_____

_____

HCA PHYSICIAN SERVICES

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: Will the Protected Health Information (PHI) be created or used for research and include treatment of the patient? If yes, complete the Authorization for Research Form. If no, proceed to Section B.

Section B: Required for all Authorizations for Release of PHI or Right to Access

Patient Name:	Birth Date:	Social Security No. *(optional)*:
Patient's Address:	Requestor's Name/Phone Number (if patient is not the requestor):	
PHI Recipient Name:	Address/City/State/Zip	Phone Number: (__) _____ Fax Number: (__) _____
PHI Sender Name:	Address/City/State/Zip	Phone Number: (__) _____ Fax Number: (__) _____

This authorization will expire on the following: (Fill in the Date or the Event, but not both.)
Date: Event:

Purpose of Disclosure:

Is this request for psychotherapy notes?
☐ Yes, then this is the only item you may request on this authorization.
☐ No, then you may check as many items below as you need.

Description:	Date(s)	Description:	Date(s)	Description:	Date(s)
☐ All PHI in record		☐ Physician Orders		☐ Demographics	
☐ History and Physical		☐ Laboratory		☐ Rehabilitation Services	
☐ Consult Report		☐ Imaging/Radiology		☐ Special Test/Therapy	
☐ Operative Report		☐ Nursing Notes		☐ Itemized Bill/Claims	
☐ Progress Notes		☐ Medication Record		☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not, applicable, check here ☐

I understand that:

1. I may refuse to sign this authorization and my treatment will not be conditioned upon signature of this authorization (except for non-health related services such as pre-employment testing, life insurance exams, or drug screenings).
2. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
3. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
4. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
5. I will receive a copy of this form after I sign it.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Guardian/Patient Representative:	Date:
Print Name of Patient's Representative:	Relationship to Patient:

Original – Practice
Copy – Patient
Copy – Recipient

HIM.PRI.001, PS 70-190 Authorizations

Revision Date: April 15, 2005