

Patient Information Sheet

Fort Bend Gastroenterology Associates

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This section for office use.

New patient Established patient

Abstractor: _____ Date: ____/____/____

Patient Information

Last Name _____ First Name _____ Middle Initial _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-mail Address _____ Marital Status _____

Social Security Number: ____ - ____ - ____ Date of Birth: ____ / ____ / ____ Sex: Male Female

Emergency Contact

Last Name _____ First Name _____ Middle Initial _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-mail Address _____ Relationship _____

Employment

Status: Retired Full-Time Part-Time Unemployed Other: _____

Name of Employer (Company Name) _____ Occupation _____ Phone Number: (____) ____ - _____

Address _____

City _____ State _____ Zip Code _____

Primary Insurance

What is the name of your insurance provider: Medicare Medicaid

Other (Please Specify): _____ Effective Date: ____ / ____ / ____

Name of policy holder: Last Name _____ First Name _____ Middle Initial _____ Relationship to Patient _____

Phone: (____) ____ - ____

Social Security Number of Policy Holder: ____ - ____ - ____ Birthdate of Policy Holder: _____

Insurance Identification Number: _____ Group Identification Number: _____

I attest that the insurance information noted above is the only coverage I have at the current time. Unless recorded above, I have no secondary insurance coverage,

Signature _____ Date: _____

Secondary Insurance

What is the name of your insurance provider: Medicare Medicaid

Other (Please Specify): _____ Effective Date: ____/____/____

Name of policy holder: Last Name First Name Middle Initial Relationship to Patient

Phone: (____) _____ - _____

Social Security Number of Policy Holder: _____ - _____ - _____ Birthdate of Policy Holder: _____

Insurance Identification Number: _____ Group Identification Number: _____

I understand that my charges will be filed with my secondary and tertiary coverage and that I am responsible for the co-pay and deductible of my primary carrier if these charges are not covered by other carriers.

Signature _____ Date _____

Insurance Assignment and Release

I certify that I have coverage with the above cited company(s) and assign, directly to Dr. Stein, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature _____ Date: _____

Medications

List all medications you take, prescription and nonprescription, and their dosage:

No medications

Medication

Dose

- | | | |
|-----|-------|-------|
| 1. | _____ | _____ |
| 2. | _____ | _____ |
| 3. | _____ | _____ |
| 4. | _____ | _____ |
| 5. | _____ | _____ |
| 6. | _____ | _____ |
| 7. | _____ | _____ |
| 8. | _____ | _____ |
| 9. | _____ | _____ |
| 10. | _____ | _____ |

For additional Medications check this box and add on reverse side

Patient Name _____

DOB: _____

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Medication Allergies

Please check if you are allergic to any of the following medications or foods:

Medication	Reaction	Medication	Reaction
<input type="checkbox"/> Aspirin	_____	<input type="checkbox"/> Naprosyn (Naproxen)	_____
<input type="checkbox"/> Advil, Motrin (Ibuprofen)	_____	<input type="checkbox"/> Penicillin	_____
<input type="checkbox"/> Augmentin (Amoxicillin)	_____	<input type="checkbox"/> Pepcid (Famotidine)	_____
<input type="checkbox"/> Bactrim (Sulfamethoxazole)	_____	<input type="checkbox"/> Prevacid (Lansoprazole)	_____
<input type="checkbox"/> Benadryl (Diphenhydramine)	_____	<input type="checkbox"/> Prilosec (Omeprazole)	_____
<input type="checkbox"/> Cipro (Levaquin)	_____	<input type="checkbox"/> Sulfa	_____
<input type="checkbox"/> Codeine	_____	<input type="checkbox"/> Tetanus	_____
<input type="checkbox"/> Demerol (Meperidine)	_____	<input type="checkbox"/> Tetracycline	_____
<input type="checkbox"/> Erythromycin	_____	<input type="checkbox"/> Tylenol (Acetaminophen)	_____
<input type="checkbox"/> Flagyl	_____	<input type="checkbox"/> Other: _____	_____
<input type="checkbox"/> Latex	_____		_____

Food Allergies

Food	Reaction	Food	Reaction
<input type="checkbox"/> Chocolate	_____	<input type="checkbox"/> Peanuts	_____
<input type="checkbox"/> Corn	_____	<input type="checkbox"/> Red dye	_____
<input type="checkbox"/> Eggs	_____	<input type="checkbox"/> Rice	_____
<input type="checkbox"/> Iodine or shellfish	_____	<input type="checkbox"/> Soy	_____
		<input type="checkbox"/> Strawberries	_____
		<input type="checkbox"/> Wheat	_____
		<input type="checkbox"/> Other: _____	_____
		<input type="checkbox"/> Other: _____	_____

Past Medical History

Please indicate if you have ever experienced any of the following conditions. Please include the date of experience.

<input type="checkbox"/> Alcohol dependence	____/____/____	<input type="checkbox"/> Diabetes Type I	____/____/____	<input type="checkbox"/> Kidney stones	____/____/____
<input type="checkbox"/> Allergies	____/____/____	<input type="checkbox"/> Diabetes Type II	____/____/____	<input type="checkbox"/> Other kidney disease	____/____/____
<input type="checkbox"/> Anemia	____/____/____	<input type="checkbox"/> Disc degeneration	____/____/____		
<input type="checkbox"/> Angina	____/____/____	<input type="checkbox"/> Duodenal ulcer	____/____/____	<input type="checkbox"/> Liver disease	_____
<input type="checkbox"/> Anxiety	____/____/____	<input type="checkbox"/> Emphysema	____/____/____	<input type="checkbox"/> Low blood pressure	____/____/____
<input type="checkbox"/> Arthritis	____/____/____	<input type="checkbox"/> Esophageal reflux	____/____/____	<input type="checkbox"/> Migraines	____/____/____
<input type="checkbox"/> Asthma	____/____/____	<input type="checkbox"/> Gallbladder stones	____/____/____	<input type="checkbox"/> Mixed hyperlipidemia	____/____/____
<input type="checkbox"/> Blood clots	____/____/____	<input type="checkbox"/> Goiter	____/____/____	<input type="checkbox"/> Obesity	____/____/____
<input type="checkbox"/> Broken bones	____/____/____	<input type="checkbox"/> Gout	____/____/____	<input type="checkbox"/> Osteoarthritis	____/____/____
<input type="checkbox"/> Cancer	____/____/____	<input type="checkbox"/> Heart attack	____/____/____	<input type="checkbox"/> Osteoporosis	____/____/____
Type: _____		<input type="checkbox"/> Heart disease	____/____/____	<input type="checkbox"/> Palpatations	____/____/____
<input type="checkbox"/> Chronic blood thinner use	____/____/____	<input type="checkbox"/> Other heart disease	____/____/____	<input type="checkbox"/> Rheumatoid Arthritis	____/____/____
<input type="checkbox"/> Chronic bronchitis	____/____/____			<input type="checkbox"/> Sciatica	____/____/____
<input type="checkbox"/> Chronic fatigue syndrome	____/____/____	<input type="checkbox"/> Heart failure	____/____/____	<input type="checkbox"/> Seizures/epilepsy	____/____/____
<input type="checkbox"/> Chronic hepatitis	____/____/____	<input type="checkbox"/> Hepatitis	____/____/____	<input type="checkbox"/> Sleep apnea	____/____/____
<input type="checkbox"/> Chronic kidney disease	____/____/____	<input type="checkbox"/> High blood pressure	____/____/____	<input type="checkbox"/> Stomach ulcer	____/____/____
<input type="checkbox"/> Chronic neck pain	____/____/____	<input type="checkbox"/> High cholesterol	____/____/____	<input type="checkbox"/> Stroke (CVA)	____/____/____
<input type="checkbox"/> Chronic sinusitis	____/____/____	<input type="checkbox"/> Irregular heart rhythm	____/____/____	<input type="checkbox"/> Thyroid disease	____/____/____
<input type="checkbox"/> Circulatory disease	____/____/____	<input type="checkbox"/> Hypertension	____/____/____	<input type="checkbox"/> Tinnitus	____/____/____
<input type="checkbox"/> Colitis	____/____/____	<input type="checkbox"/> Hyperthyroidism	____/____/____	<input type="checkbox"/> Tuberculosis	____/____/____
<input type="checkbox"/> Congestive heart failure	____/____/____	<input type="checkbox"/> Insomnia	____/____/____	<input type="checkbox"/> Other: _____	____/____/____
<input type="checkbox"/> COPD	____/____/____	<input type="checkbox"/> Irritable bowel	____/____/____		
<input type="checkbox"/> Crohn's disease	____/____/____	<input type="checkbox"/> syndrome	____/____/____		
<input type="checkbox"/> Depression	____/____/____				

Surgical History

Please check all that apply.

	Date		Date		Date
<input type="checkbox"/> Angioplasty	_____	<input type="checkbox"/> Cholecystectomy	_____	<input type="checkbox"/> LASIK	_____
<input type="checkbox"/> Angioplasty w/ stent	_____	<input type="checkbox"/> Colectomy	_____	<input type="checkbox"/> Liver biopsy	_____
<input type="checkbox"/> Appendectomy	_____	<input type="checkbox"/> Colostomy	_____	<input type="checkbox"/> Open Reduction	_____
<input type="checkbox"/> Arthroscopy knee	_____	<input type="checkbox"/> Gastric bypass	_____	<input type="checkbox"/> Internal Fixation	_____
<input type="checkbox"/> Back surgery	_____	<input type="checkbox"/> Hernia repair	_____	<input type="checkbox"/> Pacemaker	_____
<input type="checkbox"/> Coronary Artery Bypass Graft	_____	<input type="checkbox"/> Hip replacement	_____	<input type="checkbox"/> Small bowel resection	_____
<input type="checkbox"/> Carpal tunnel release	_____	<input type="checkbox"/> Hysterectomy	_____	<input type="checkbox"/> Thyroidectomy	_____
<input type="checkbox"/> Cataract extraction	_____	<input type="checkbox"/> Knee replacement	_____	<input type="checkbox"/> Tonsillectomy	_____
<input type="checkbox"/> Other: _____					
<input type="checkbox"/> Other: _____					

Family History

Please check if any family member has had any of the following conditions and indicate the name of the affected member, the age of onset and/or if it was the cause of death. Adopted

	Mother	Father	Sibling(s)	Grandparents	Children	Cause of Death
<input type="checkbox"/> ADD/ADHD						
<input type="checkbox"/> Alcoholism						
<input type="checkbox"/> Allergies						
<input type="checkbox"/> Alzheimer's disease						
<input type="checkbox"/> Asthma						
<input type="checkbox"/> Blood disease						
<input type="checkbox"/> Heart disease						
<input type="checkbox"/> Heart disease before age 50						
<input type="checkbox"/> Cancer						
Type: _____						
<input type="checkbox"/> Depression						
<input type="checkbox"/> Diabetes						
<input type="checkbox"/> Eczema						
<input type="checkbox"/> Hearing deficiency						
<input type="checkbox"/> High cholesterol						
<input type="checkbox"/> Hypertension						
<input type="checkbox"/> Inflammatory Bowel Disease						
<input type="checkbox"/> Kidney disease						
<input type="checkbox"/> Learning disability						
<input type="checkbox"/> Mental illness						
<input type="checkbox"/> Migraines						
<input type="checkbox"/> Obesity						
<input type="checkbox"/> Osteoporosis						
<input type="checkbox"/> Peripheral Vascular Disease						
<input type="checkbox"/> Seizures/epilepsy						
<input type="checkbox"/> Stroke (CVA)						
<input type="checkbox"/> Other: _____						
<input type="checkbox"/> Other: _____						
<input type="checkbox"/> Other: _____						

Patient Name: _____

DOB: _____

Social History

Do you use tobacco? Yes No Former Type of tobacco used? _____/_____
 Packs per day? _____ Years smoked? _____ Year Quit? _____
 Other Tobacco units per day (cans, cigars, etc)? _____
 Units per day? _____ Years used? _____ Year Quit? _____

Do you drink caffeine? Yes No Type? _____ Amount Daily? _____

Do you drink alcohol? Yes No Former Year Quit? _____
 Type? _____ How much per week? _____
 Amount? _____ Last Drink? _____

Do you have a preferred pharmacy? Yes No
 Pharmacy: _____ Phone Number: _____
 Address: _____
 Pharmacy: _____ Phone Number: _____
 Address: _____

Immunizations

Adult Immunizations – Please check and indicate the immunization date to all that apply.

	Series # 1	Series # 2	Series # 3	Series # 4	Series # 5	Date of last
<input type="checkbox"/> Hepatitis B (HBV)	_/_/___	_/_/___	_/_/___	_/_/___	_/_/___	
<input type="checkbox"/> Pneumococcal (PPV23)	_/_/___	_/_/___				
<input type="checkbox"/> Measles, Mumps, Rubella (MMR)	_/_/___	_/_/___				
<input type="checkbox"/> Varicella (Chicken Pox) (VAR)	_/_/___	_/_/___				
<input type="checkbox"/> Influenza (LAIV)	_/_/___	_/_/___				_/_/___
<input type="checkbox"/> Meningococcal (MCV4/MPSV4)	_/_/___	_/_/___				
<input type="checkbox"/> Tetanus & Diphtheria (Td)	_/_/___	_/_/___	_/_/___	_/_/___	_/_/___	_/_/___
<input type="checkbox"/> Adult Tetanus, Diphtheria, Pertussis (Tdap)	_/_/___					
<input type="checkbox"/> Hepatitis A (HAV)	_/_/___	_/_/___	_/_/___			
<input type="checkbox"/> Varicella Zoster (ZOS)	_/_/___					
<input type="checkbox"/> Human Papillomavirus (HPV)	_/_/___	_/_/___	_/_/___			
<input type="checkbox"/> Other: _____	_/_/___	_/_/___	_/_/___	_/_/___	_/_/___	_/_/___
<input type="checkbox"/> Other: _____	_/_/___	_/_/___	_/_/___	_/_/___	_/_/___	_/_/___
<input type="checkbox"/> Other: _____	_/_/___	_/_/___	_/_/___	_/_/___	_/_/___	_/_/___

Health Maintenance

Colonoscopy Yes No Date of last _____
 Influenza Vaccine Yes No _____

Disease Management

Abdominal Ultrasound Yes No Date of last _____
 Chest X-Ray Yes No _____

Advance Directives

Do you have any of the following in place?

Date Reviewed: _____

None

DNR

Living Will

Durable Power of Attorney

HC Proxy

SIGNATURE ON FILE

I directly assign all Medical/Surgical benefits to Ft. Bend Gastroenterology.

I authorize the doctor to release all information necessary to secure the payment of benefits.

I understand that I am responsible for my bill.

I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.

I authorize payment directly to the doctor

I agree that a photocopy of this agreement shall be as valid as the original.

Sign Here _____ Date: _____
Patient or Legal Representative

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICIES

The office staff of Stanley H. Stein, M.D. has offered me a copy of the Notice of Privacy Practices and I have been provided an opportunity to review it.

Sign Here _____ Date: _____

Patient Name: _____ DOB: _____

Appointment Date: _____

Please fax completed form to (281) 762-6339 prior to your appointment whenever possible.