Etowah Gastroenterology Associates
Vipul T. Amin, M.D.

Patient Information

PATIENT NAME (LAST, FIRST, MIDDLE)					HOME TELEPHONE		CELL TELEPHONE
ADDRESS		CITY		STATE		ZIP CODE	
PATIENT'S EMPLOYER					OCCUPATION (INDICATE IF STUDENT)		WORK TELEPHONE
SEX ☐M ☐F	RACE	AGE	MARTIAL STATUS ☐S ☐M ☐D ☐W	BIRTHDATE	RETIRED ☐Y ☐N	DISABLED ☐Y ☐N	SOCIAL SECURITY NO.
SPOUSE'S NAME				SPOUSE'S EMPLOYER			SPOUSE'S WORK TELEPHONE
NEXT OF KIN (NOT LIVING WITH YOU)							DAYTIME TELEPHONE
FRIEND (NOT LIVING WITH YOU)							DAYTIME TELEPHONE
WHOM MAY WE CONTACT IN CASE OF EMERGENCY							DAYTIME TELEPHONE
REFERING PHYSICIAN				FAMILY PHYSICIAN			
PHARMACY		PREFERRED LANGUAGE		ETHNICITY			EMAIL ADDRESS
PERSON RESPONSIBLE FOR PAYMENT					RELATION TO PATIENT		
ADDRESS	CITY	STATE	ZIP CODE		HOME TELEPHONE		SOCIAL SECURITY NO.
BIRTHDATE	EMPLOYER				WORK TELEPHONE		
NAME OF PRIMARY INSURANCE CO.			CONTRACT NO.		GROUP NO.		EFFECTIVE DATE
NAME OF INSURED (AS IT APPEARS ON YOUR INSURANCE CARD)							
NAME OF SECONDARY INSURANCE CO.			CONTRACT NO.		GROUP NO.		EFFECTIVE DATE
NAME OF INSURED (AS IT APPEARS ON YOUR INSURANCE CARD)							

I (Or my legal guardian or parent) authorize Etowah Gastroenterology Assoc. to provide medical care reasonable by today's standards.

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO Etowah Gastroenterology Associates, P.C. of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but not to exceed the physician's regular charges for these services. I understand that I am financially responsible to Etowah Gastroenterology Assoc., P.C. for charges not covered by this assignment. I authorize the refund of overpaid benefits where my coverage's are subject to coordination of benefits. In the event of default, I agree to pay all costs of collection including reasonable attorney's fees, and waiver all claims of exemption under the law of the State of Alabama.

By signing this form, you are granting consent to Etowah Gastroenterology Assoc. to use and disclose your protected health information for the purposes of treatment, payment, and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent and we encourage you to read it in full. Our Notice of Privacy Practices is subject to change. If we change out notice, you may obtain a copy of the revised notice by contacting our organization at (256) 467-4477. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment, or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Signature of patient/legal guardian: _____ Date_____

Etowah Gastroenterology Associates

1026 Goodyear Avenue, Suite 2012 • Gadsden AL, 35901 Tel (256) 467-4477 • Fax (256) 467-4830
Vipul Amin, M.D.

MEDICAL HISTORY

Name: _____ Age: _____ Date: _____
Referring Physician: _____

One of the most important parts of the medical record your doctor keeps about you is a health history concerning your past and present health problems and any personal information which might affect the state of your health. In an attempt to gain insight into your medical needs and problems we are requesting that you answer the following questions. Your answers will be treated confidentially as are all parts of your visit. Take all the time you need to complete this questionnaire. Answer each question as best you can by filling in the information asked. We appreciate your cooperation.

CHIEF COMPLAINT (*describe in your own words the main reason you are seeing the doctor today*):

_____
_____
_____
_____
_____
_____
_____
_____
_____

PREVIOUS AND CURRENT MEDICAL ILLNESSES:

_____
_____
_____
_____
_____
_____
_____
_____
_____

HISTORY OF PREVIOUS SURGURIES (*List any previous surgeries and date*):

_____
_____
_____
_____

PRESENT MEDICATIONS (*List all prescription and nonprescription medications you are currently taking*):

_____
_____
_____
_____
_____

ALLERGIES (*List any allergy or precious drug reactions*):

Have you ever had a blood transfusion? _____
Year you received the transfusion: _____

SOCIAL HISTORY

- Do you smoke? ☐Yes ☐No
  approximate amount per day _____
- Do you drink alcohol? ☐Yes ☐No
  approximate amount per day _____
- Have you ever used any intravenous drugs?
  ☐Yes ☐No
- Have you ever had any tattoos? ☐Yes ☐No
- Have you traveled outside the US within the past year?
  ☐Yes ☐No
  If Yes, where? _____

FAMILY HISTORY

Is there any family member with any of these diseases?

☐Colon Cancer	Mother, Father, Grandparents, Brother/Sister
☐Crohn's Disease	Mother, Father, Grandparents, Brother/Sister
☐Alcoholism	Mother, Father, Grandparents, Brother/Sister
☐Irritable Bowel (Spastic Colon)	Mother, Father, Grandparents, Brother/Sister
☐Colom Polyps	Mother, Father, Grandparents, Brother/Sister
☐Ulcerative Colitis	Mother, Father, Grandparents, Brother/Sister
☐Liver Disease	Mother, Father, Grandparents, Brother/Sister

REVIEW OF SYSTEM

Please circle only those symptoms that you "frequently" have:

Head and Neck	
Headaches	Sinus drainage
Hoarseness	
Heart-Cardiovascular	
Cheat Pain	Palpitations
Ankles Swell	
Lungs-Pulmonary	
Difficulty Breathing	Chronic Cough
Spilt-Up Blood	
Gastrointestinal	
Abdominal Pains	Heartburn
Indigestion	Slow Digestion
Nausea	Difficulty Swallowing
Appetite Loss	Weight Loss
Vomit Blood	Black Tarry Stools
Blood from Rectum	Chronic Diarrhea
Skin Turns Yellow	Hepatitis
Clay Colored Stool	Hemorrhoids
Night Sweats	Bloating
Nervous System	
Depression	Nervous Breakdown
Excessive Stress	

You may use the back side of this page for any other problems or notes you may want to add to your history.

ETOWAH GASTROENTEROLOGY ASSOCIATES, PC

PATIENT'S NAME: _____ Date of Birth:_____

REVIEW OF SYSTEMS (circle or underline)

CONSTITUTIONAL/GENERAL

Fever	yes	no
Chills	yes	no
Fatigue	yes	no
Sleep difficult	yes	no
Weight loss	yes	no

ALLERGY/IMMUNOLOGY

oral ulcerations	yes	no
hives	yes	no
blistering of skin	yes	no
rash	yes	no
itching	yes	no

ENDOCRINOLOGY

excessive sweating	yes	no
thermal sensitivity	yes	no
excessive thirst	yes	no
heat intolerance	yes	no
change of appetite	yes	no

RESPIRATORY

Chest pain	yes	no
Cough	yes	no
Short of breath	yes	no
Sputum	yes	no
Hemoptysis	yes	no
Wheezing	yes	no

CARDIOVASCULAR

palpitations	yes	no
chest pain at rest	yes	no
cyanosis	yes	no
claudication	yes	no
leg swelling	yes	no
irregular heartbeats	yes	no

HEMATOLOGY

easy brushing	yes	no
anemia	yes	no
prolonged bleeding	yes	no
swollen glands/nodes	yes	no
blood transfusion	yes	no

GENITOURINARY

Blood in urine	yes	no
Frequent urine	yes	no
Difficulty urine	yes	no
Painful urine	yes	no

MUSCULOSKELETAL

painful joints	yes	no
swollen joints	yes	no
joint stiffness	yes	no
back pain	yes	no

PERIPHERAL VASCULAR

blanching of skin	yes	no
painful extremities	yes	no
absent pulses in hand	yes	no
absent pulses in leg	yes	no

DERMATOLOGY/SKIN

Rashes	yes	no
Photo sensitive	yes	no
Itching	yes	no

NEUROLOGY

seizure	yes	no
tingling/numbness	yes	no
transient blindness	yes	no

PYSCHIATRIC

eating disorders	yes	no
anxiety	yes	no
sleeping disorder	yes	no

OB/GYN HISTORY

menstrual abnormality yes no

are you pregnant currently yes no

Last menstrual period date:_____

SIGNATURE: _____

PERMISION TO DISCLOSE PROTECTED HEALTH INFORMATION
CONSENT AND ACKNOWLEDGEMENT FOR
ETOWAH GASTROENTEROLOGY ASSOCIATES, P.C.
(PLEASE PRINT)

Patient Name: _____ Date of Birth: _____
Patient Address: _____ SSN: _____
_____

I give Etowah Gastroenterology Associates, P.C. permission to release medical information to the follow persons:
☐ None
☐ Parents _____ ☐ Spouse _____
☐ Father (only) _____ ☐ Mother (only) _____
☐ Other _____ ☐ Guardian _____
☐ Physicians _____ Fax # _____ Phone # _____

I wish to be contacted in the following manner by Etowah Gastroenterology Associates, P.C. (check all that apply):

☐ **Home Telephone** _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call back number only

☐ **Cell Phone** _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call back number only

☐ **Work Telephone** _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call back number only

☐ **Written Communication**
- ☐ O.K. to mail or Email to my home address
- ☐ O.K. to mail or Email to my work/office
- ☐ O.K. to fax to this number

☐ **Other (Email Address)** _____
_____
_____
_____
_____

The Privacy Act generally requires healthcare providers to take responsible steps to limit the use of disclosure of and requests for protected health information to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of protected health information disclosures. Information provided below, if completed properly, will constitute an adequate record.

Consent:
I consent to the use and disclosure of protected health information about me by my physician and my physician's practice for purposes of treatment, payment, health care operations, protection of others and disclosures required by law, including information about notifiable diseases, sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) and human immunodeficiency virus (HIV).

NOTE: Uses and disclosures for protected health information may be permitted without prior consent in an emergency.

ACKNOWLEDGMENTS:
I acknowledge that I have received Etowah Gastroenterology Associates, P.C. Notice of Privacy Practices.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Relationship of Personal Representative to the Patient Signature of Witness

_____
Print Personal Representative's Name