CENTER FOR DIGESTIVE HEALTH

Michael P. Dohrenwend, MD
7738 B Madison Blvd.
Huntsville, Al 35806
256-430-4427

Welcome!

Thank you for selecting our healthcare team! We will strive to provide you with the best possible care. To help us meet your healthcare needs, please fill out this form **completely**. If you have any questions or need assistance, please ask us. We will be happy to help!

Today's Date:_____ **Birthdate**:_____**SS#**:_____

PERSONAL INFORMATION

Patient's Name:_____ M F

Street Address:_____

City:_____ ST:_____ Zip:_____

Employer/School:_____

Occupation:_____

TELEPHONE

Home Phone:_____

Mobile Phone:_____

Work Phone:_____

May we leave a message on your answering machine? ☐ Yes ☐ No

May we email you? ☐ Yes ☐ No Email Address:_____

RELEASE OF INFORMATION

I authorize the release of information (including facsimile transmission) relative to my medical record and/or lab results to: ☐ Myself Only ☐ My Spouse ☐ My Child ☐ Legal Ward:_____ ☐ Other:_____

FOR OFFICE USE

I revoke the above authorization because _____

_____ Date:_____ Initials_____

EMERGENCY

In the event of an emergency please contact:

Name:_____ Relationship:_____

Home Number:_____ Mobile Number:_____

INSURANCE INFORMATION

Primary Insurance (Please provide insurance cards for us to copy)

Plan Name:_____ ID#_____ Group#_____

Name of Insured:_____ Copay:_____

Relationship to patient:_____

Insured's DOB:_____ Insured's SSN:_____

Secondary Insurance (Please provide insurance cards for us to copy)

Plan Name:_____ ID#_____ Group#_____

Name of Insured:_____ Copay:_____

Relationship to patient:_____

Insured's DOB:_____ Insured's SSN:_____

Please turn over the page and complete the back page

PERSON TO BILL Who will ***pay*** for services not covered by insurance?

Name:_____

Relationship to Patient: _____ DOB: _____

Street Address: _____SSN: _____

City: _____ ST: _____ Zip: _____

Work Phone: _____ Home Phone: _____

Note: We accept personal checks, cash and credit cards. We **do not** process debit card payments. Patient balances over 30 days old are subject to a 10% monthly service charge. (120% annually)

I have read and understand the practice policies regarding patient expectations.

X_____

Signature Date

AUTHORIZATION AND RELEASE

I hereby authorize The Center for Digestive Health to release any information regarding service rendered to me or my child (including diagnoses, record of treatment or examination) to third party payers in consideration of payment for my care or to other healthcare practitioners involved in providing my/my child's care. I authorize and request my insurance company/ Medicare/Medicaid to pay benefits otherwise payable to me directly to the physician. I understand that my insurance carrier/Medicare/Medicaid/benefit provider may pay less than the actual bill for the services; and I agree that I am responsible for payment of all services rendered regardless of insurance coverage. Should this account be turned over to collections, I am responsible for all costs of collections as well as attorney fees.

Signature of patient (or parent if minor): _____ Date: _____

NOTICE OF PRIVACY ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct the record. We will not disclose your record to others unless you direct us to do so or unless the law authorized or compels us to do so. You may see your record or get more information about it by contacting our privacy officer. Our Notice of Privacy describes more in detail how your health information may be used and disclosed and how you access your information. By my signature below I acknowledge receipt of the Notice of Privacy Practices

_____ _____

Patient or legally authorized individual signature Date

FOR OFFICE USE

Good faith attempt has been made to provide the patient with our Notice of Privacy Practices.

_____ _____

Employee Signature Date Witness Signature Date

Thank you for filling out this form completely. The information you have provided will help us serve your healthcare needs more effectively and efficiently. Updated: 2016

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Date of Appointment:_____/_____/_____ Sex:_____Female _____Male

Name:_____ Age:_____ Date of Birth: _____/_____/_____

Referring Physician: _____ Family Physician: _____

Reason for visit today: _____ How long have you had this problem?_____

Are there any factors that make this better or worse?_____

List any tests done for this problem already:

1)_____ 2)_____ 3) _____

List current medications with dosages including over-the-counter or herbal (ask for extra paper if more than six meds.)

1)_____ 2)_____ 3) _____

4)_____ 5)_____ 6) _____

List Drug Allergies:

1)_____ 2)_____ 3) _____

PAST HISTORY: List any illnesses or diseases that you are being treated for or have been treated for in the past

1)_____ 2)_____ 3) _____

4)_____ 5)_____ 6) _____

SURGERIES OR OPERATIONS: Year Surgeon City

1)_____

2)_____

3)_____

4)_____

ANY OF THESE PROBLEMS IN THE PAST YEAR?

Chronic Fatigue	____No ____Yes
Loss of Appetite	____No ____Yes
Heartburn	____No ____Yes
Trouble Swallowing	____No ____Yes
Painful Swallowing	____No ____Yes
Nausea	____No ____Yes
Vomiting	____No ____Yes
Stomach Pain	____No ____Yes
Liver Problems	____No ____Yes
Stomach Ulcers	____No ____Yes
Aspirin use/BC Powder use	____No ____Yes
Diarrhea	____No ____Yes
Constipation	____No ____Yes
Change of Bowel Habit	____No ____Yes
Blood in Stool	____No ____Yes
Black Stool	____No ____Yes
Mucous in Stool	____No ____Yes
Gallbladder Problems	____No ____Yes
Incomplete Bowel Evacuation	____No ____Yes
Bowel Incontinence	____No ____Yes

SOCIAL HISTORY:

Do you smoke? ___ No ___ Yes ___ Past
Cigarettes per day: _____
Do you drink alcohol? ___ No ___ Yes ___ Past
Daily alcohol intake: _____

Do you use Intravenous Drugs? ___ No ___ Yes ___ Past
Daily intake of coffee/caffeinated beverages: _____
Have you received a blood transfusion? ___ No ___ Yes
Number of Children: _____

Marital Status: __ Single __ Married __ Divorced __Widowed __Separated

FAMILY HISTORY:

	Age	Serious Health Problems	Cause of Death
Father:			
Mother:			
Brother:			
Sister:			

Which of your family members have had any of the following:

Colon Cancer: _____ Stomach Ulcer: _____ Gallstones: _____
Colitis/Crohn's: _____ Stomach/Esophageal Cancer: _____ Pancreatitis: _____
Colon Polyps: _____ Liver Disease: _____ Bleeding Tendency/ Anemia: _____
Breast Cancer: _____

HAVE YOU HAD ANY OF THESE PROBLEMS IN THE PAST YEAR?

GENERAL
Chronic Fatigue ___ No ___ Yes
Weight Loss ___ No ___ Yes
Amount _____ since when? _____
Fever ___ No ___ Yes

SKIN/BREAST
Bruising ___ No ___ Yes
Rash/Itching ___ No ___ Yes
Lumps ___ No ___ Yes
Color Change ___ No ___ Yes

HEMATOLOGY/LYMPHTI
Anemia ___ No ___ Yes
Bleeding ___ No ___ Yes
Enlarged Nodes ___ No ___ Yes
Painful Nodes ___ No ___ Yes

MUSCULOSKELETAL
Arthritis ___ No ___ Yes
Weakness ___ No ___ Yes
Fracture ___ No ___ Yes

ENDOCRINE
Thyroid ___ No ___ Yes
Diabetes ___ No ___ Yes

ALLERGY/IMMUNOLOGY
Sinus ___ No ___ Yes
Eczema ___ No ___ Yes
Allergy Testing ___ No ___ Yes

EYES
Vision Loss ___ No ___ Yes
Glasses/Contacts ___ No ___ Yes
Cataracts ___ No ___ Yes

ENT
Deafness ___ No ___Yes
Dizziness ___ No ___Yes
Runny nose ___ No ___ Yes
Mouth sore ___ No ___ Yes
Throat sore ___ No ___ Yes
Nose bleed ___ No ___ Yes
Hoarseness ___ No ___ Yes

RESPIRATORY
Asthma ___ No ___Yes
Wheezing ___ No ___ Yes
TB ___ No ___ Yes
Cough ___ No ___ Yes
Sputum ___ No ___ Yes
Emphysema ___ No ___ Yes
Bronchitis ___ No ___ Yes
Pneumonia ___ No ___ Yes
COPD ___ No ___ Yes
Sleep Apnea ___ No ___ Yes
CPAP ___ No ___Yes

CARDIOVASCULAR
Angina ___ No ___ Yes
Chest Pain ___ No ___ Yes
Rheumatic Fever ___ No ___ Yes
Palpitations ___ No ___Yes
Heart Attack ___ No ___Yes
Hypertension ___ No ___Yes

GENITOURINARY
Kidney Stones ___ No ___ Yes
Increased Urine ___ No ___ Yes
Change in Urine Color ___ No ___ Yes

Hysterectomy/Tubal ___No ___ Yes
Hormones ___No ___ Yes
Birth Control Pills ___No ___ Yes
Incontinence ___No ___ Yes
Prostate ___No ___ Yes
Last Menstrual Period: _____
Date of Menopause: _____
#pregnancies/abortions/miscarriages: _____

NEUROLOGIC
Stroke ___No ___Yes
Seizure ___No ___Yes
Paralysis ___No ___Yes
Numbness ___No ___Yes

PSYCHIATRIC
Anxiety ___No ___Yes
Depression ___No ___Yes
Hallucinations ___No ___Yes

Date of Last Colonoscopy: _____

_____

_____

Date of Last EGD: _____

_____

FOR OFFICE USE ONLY: Height: _____ Weight: _____ Temp: _____

Pulse: _____ BP: _____

Updated: 2018

CENTER FOR
DIGESTIVE HEALTH

Michael P. Dohrenwend, MD
Board Certified, Gastroenterology

Patient Policies: Doctor/Patient relationships are usually lasting associations and should be built on trust and mutual respect. We want to take exceptional care of your health and we ask for your help in ensuring it. The following policies are designed to keep our office running smoothly for all our patients.

Appointments

If you cannot keep your scheduled appointment, please give us at least 24 hours notice for cancelations. We need at least one day's notice so that we can offer the appointment slot to another patient. We keep a record in your chart of all missed appointments. We reserve the right to charge for missed appointments when we are not provided a 24 hour notice. Patients who have a pattern of cancellations may also be asked to make a $50 rescheduling fee before their next appointment is scheduled.

Medications

Please be sure to bring a complete list of all your medications to each visit. Likewise, please be compliant in following all of Dr. D's instructions with the medications he prescribes for you. This is of vital importance in evaluating your progress. Because we chart in your records, any medication refills or prescription changes, we cannot refill medications outside of regular business hours. We will only fill prescriptions when we have access to patient charts.

Payments

Patients are expected to make their co-payments at time of service. We accept cash, checks, and credit card payments. **Note: There is a $2.00 service charge to run the credit card.** Only copays are made at the office. If you receive a bill in the mail, please follow the mailing instructions on the bill. If you are a non-insured or self-pay patient, there is a $150 cash-only fee for the initial office visit and a fee of $100 will be charged for each subsequent office visit.

Scheduled Procedures

If you are scheduled for a procedure, please follow all of the prep instructions carefully. The quality of your prep can greatly effect the results of your procedure. All patients will receive a written report, and usually pictures, at the completion of their endoscopy. Once your biopsies are done, please allow **7-10 days for results.** There are many hands working behind the scenes who are involved in your care. The process follows a natural progression that allows careful checks and balances. In an ideal situation, each member of your medical team is given adequate time to carry out their role.

Test Results

Once your x-rays, lab tests, CT scans, etc. are complete, please allow 7-10 days for results. **Note: if you have multiple tests run, Dr. D will review your procedure/test report when all the reports are in. If the results of your tests are critical, you can expect our nurse to make direct contact with you, if the results are not critical, your results will be reviewed at the time of your follow-up appointment.**

Insurance Referrals

Some insurances require a referral prior to your office visit/procedure. If your insurance requires a referral, it is the responsibility of your primary care physician to provide this to our office. If a referral is not received at the time of your appointment, the office visit will be rescheduled, until the referral has been received.

Follow-Up Visits

Follow-up visits are important to evaluate your progress, monitor your medications, explain test/procedure reports, and plan your continued care. The timing of your follow-up visits are scheduled to:

1. Allow time for medications to take effect; and/or
2. Allow healing time; and/or
3. Observe recall periods established by insurers. Ex: some insurance companies will not cover follow-up visits scheduled sooner than 6 weeks. Time must be given to allow symptoms to abate and/or medications to take effect.