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:____

City:____ ST:__________ Zip:__________

Home Phone:______________________________ Cell Phone:______________________________

Note: We accept personal checks, cash, and credit cards (debit cards will be processed as credit). 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 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 to pay benefits otherwise payable to me directly to the physician. I understand that my insurance carrier 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.

X____ ____________________________

Signature of patient (or parent if minor) Date

NOTICE OF PRIVACY ACKNOWLEDMENT

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 use your record or get information about it by contacting our privacy officer. Our Notice of Privacy is available upon request. By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

X____ ____________________________

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: _______________

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

Updated 3/2020

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Date of Appointment:_______/_______/_______ Sex:_______Female _______Male

Name:____ Age:________ Date of Birth: _______/________/________

Referring Health Care Provider: _____________________ Family Health Care Provider: ___________________

How did you hear about us? ____

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) ______________________________

7)______________________________ 8)______________________________ 9)______________________________

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 Vape/e-Cig ? __ No __ Yes __ Past
Do you drink alcohol? ___ No ___ Yes ___ Past
Daily alcohol intake: __________________

Do you use Intravenous Drugs? ___ No ___ Yes ___ Past
Marijuana Use? ___ No ___ Yes ___ Past. How often? ____________
CBD use? __No __ Yes What Form? ___________ Frequency:_____
Daily intake of coffee/caffeinated beverages: ___________________
Have you received a blood transfusion? ___ No ___ Yes

Marital Status: __ Single __ Married __ Divorced __Widowed __Separated. Number of children:____________

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: __________________
Colitis/Crohn's: _________________
Colon Polyps: __________________

Stomach Ulcer: ___________________
Stomach/Esophageal Cancer: ________
Liver Disease: ____________________

Gallstones: ______________________
Pancreatitis: _____________________
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: 2020