GI Partners of Alabama

Decatur Morgan Hospital

Michael Kelso, MD

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Patient Information

Referring Physician		Primary Care Physician		
Last Name	First Name	MI	Date of Birth	Sex ☐ M ☐ F
Address	City		State	Zip
Mobile Number	Home Number	Email		
Social Security Number	Race ☐ African American ☐ American Indian ☐ Asian ☐ Caucasian ☐ Latinx ☐ Other			
Employer	Employer Phone Number			
Employer Address	City		State	Zip
Emergency Contact Name	Emergency Contact Number	Relationship		
Pharmacy Name	Pharmacy Location	Pharmacy Phone Number		
How did you hear about our practice?	☐ Physician Referral ☐ Family/Friend ☐ Google/Search ☐ Social Media ☐ Newspaper/Magazine ☐ Website ☐ Insurance Company ☐ Other			

Insurance

Primary Insurance Company	Policy ID Number	Group Number
Subscriber Name	Relationship to Patient	Subscriber Date of Birth
Secondary Insurance Company	Policy ID Number	Group Number
Subscriber Name	Relationship to Patient	Subscriber Date of Birth

Person Responsible for Account: _____ **Phone:** _____

I agree that payment will be made at the time of service. I agree to pay all co-pays, non-covered or routine charges, deductibles and co-insurance amounts that apply. In the event this account is turned over to a collection agency for collection, I will be responsible for all collection fees, court costs and attorney's fees. I authorize Decatur Morgan Primary Care to release information to insurance carriers and for insurance carriers to release information to Decatur Morgan Primary Care concerning my illness, treatment and payments (including workmen's compensation) and I hereby assign to the physicians all payments for medical services rendered to myself or my dependents if assignment applies.

Signature: _____ **Date:** _____

Name: _____ Date of Birth: _____

Medications

Name	Dose/Strength (mL or mg)	Frequency (How often?)

Allergies (☐ No known allergies)

Medication/Food	Reaction

Medical History (Check all that apply)

☐ NONE

☐ Barrett's Esophagus
☐ Celiac Disease
☐ Cirrhosis
☐ Colon Cancer
☐ Colon Polyps
☐ Crohn's Disease
☐ Diverticulosis
☐ End Stage Renal Disease (ESRD)
☐ Heartburn / GERD
☐ Hepatitis B
☐ Hepatitis C (HCV)
☐ H. pylori Infection
☐ Irritable Bowel Syndrome (IBS)
☐ Liver Disease
☐ Pancreatitis
☐ Stomach/Intestinal Ulcers
☐ Ulcerative Colitis
☐ Anemia
☐ Anxiety / Depression
☐ Arthritis / Osteoarthritis
☐ Asthma
☐ Cancer: Type _____
☐ Chronic Kidney Disease
☐ Congestive Heart Failure (CHF)
☐ COPD / Emphysema
☐ Coronary Heart Disease (CAD)
☐ Dementia
☐ Diabetes
☐ Enlarged Prostate
☐ Gallstones
☐ Heart Attack
☐ HIV/AIDS
☐ High Cholesterol
☐ High Blood Pressure
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Nerve / Muscle Disease
☐ Parkinson's Disease
☐ Seizures
☐ Sleep Apnea - CPAP / BiPAP
☐ Stroke
☐ Tuberculosis
☐ Other _____
☐ _____

Name: _____ Date of Birth: _____

Surgical History (Check all that apply)

☐ NONE	☐ Gallbladder Removed	☐ Liver Biopsy
☐ Appendix	☐ Gastric Bypass	☐ Mastectomy
☐ Back Surgery	☐ Gastric Lap Band	☐ Neck Surgery
☐ Blood Transfusion	☐ Gastric Sleeve	☐ Small Bowel Resection
☐ CABG (Heart Bypass)	☐ Hiatal Hernia Repair	☐ Thyroid
☐ Cardiac Pacemaker	☐ Hemorrhoidectomy	☐ Tonsillectomy
☐ Carotid Endarterectomy	☐ Inguinal / Groin Hernia Repair	☐ Valve Replacement, Heart
☐ Colon Resection / Surgery	☐ Hip Surgery	☐ Other _____
☐ ERCP	☐ Hysterectomy Complete / Partial	☐ _____
☐ EUS	☐ Kidney Removal	☐ _____
☐ Fistula (AV Graft)	☐ Knee Replacement	☐ _____

GI Procedures

When was your last colonoscopy? _____ Did you have polyps? ☐ Yes ☐ No ☐ No prior colonoscopy

Who performed your last colonoscopy? _____

When was your last EGD (upper endoscopy)? _____ Did you have Barrett's? ☐ Yes ☐ No ☐ No prior EGD

Family History

	Mother	Father	Sister	Brother	Son	Daughter	Age at diagnosis (if known)
Colon Polyps	☐	☐	☐	☐	☐	☐	_____
Crohn's Disease	☐	☐	☐	☐	☐	☐	_____
Ulcerative Colitis	☐	☐	☐	☐	☐	☐	_____
Cancers							
Breast	☐	☐	☐	☐	☐	☐	_____
Colon	☐	☐	☐	☐	☐	☐	_____
Esophagus	☐	☐	☐	☐	☐	☐	_____
Liver	☐	☐	☐	☐	☐	☐	_____
Lung	☐	☐	☐	☐	☐	☐	_____
Lynch (uterine, bladder, ureter)	☐	☐	☐	☐	☐	☐	_____
Pancreas	☐	☐	☐	☐	☐	☐	_____
Prostate		☐		☐	☐		_____
Stomach	☐	☐	☐	☐	☐	☐	_____
Other _____	☐	☐	☐	☐	☐	☐	_____
Liver Disease	☐	☐	☐	☐	☐	☐	_____
Diabetes	☐	☐	☐	☐	☐	☐	_____
Heart Disease	☐	☐	☐	☐	☐	☐	_____

Social History

Occupation ☐ Full-time ☐ Part-time ☐ Retired ☐ Disabled ☐ Not employed

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Life Partner

Tobacco (incld cigars, chewing, vape) ☐ Never ☐ Former ☐ Current (Every Day) ☐ Current (Some Days) ☐ Current (Unknown)

Alcohol (beer, wine, liquor) ☐ Never ☐ Former ☐ Current (Every Day) ☐ Current (Some Days) ☐ Current (Unknown)

Illegal Drugs _____ ☐ Never ☐ Former ☐ Current (Every Day) ☐ Current (Some Days) ☐ Current (Unknown)

Name: _____ Date of Birth: _____

Current Symptoms

- ☐ NONE

General

- ☐ Chills
- ☐ Fever
- ☐ Night sweats
- ☐ Weight loss
- ☐ Weight gain

Eyes/Ears/Nose/Throat

- ☐ Blurred vision
- ☐ Hoarseness
- ☐ Mouth sores/ulcers
- ☐ Sore throat

Cardiovascular

- ☐ Chest pain
- ☐ Heart racing / Palpitations
- ☐ Ankle / Leg swelling

Respiratory

- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing

Gastrointestinal

- ☐ Abdominal pain
- ☐ Black stools
- ☐ Blood in stools
- ☐ Bloating/gas
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Decreased appetite
- ☐ Diarrhea
- ☐ Heartburn / Reflux
- ☐ Incontinence of stool
- ☐ Nausea
- ☐ Painful swallowing
- ☐ Rectal / Anal pain / Itching
- ☐ Trouble swallowing
- ☐ Vomiting

Genitourinary

- ☐ Blood in urine
- ☐ Heavy cycles
- ☐ Trouble urinating

Musculoskeletal

- ☐ Back pain
- ☐ Joint pain

Neurological

- ☐ Confusion
- ☐ Dizziness / Vertigo
- ☐ Headaches
- ☐ Numbness
- ☐ Weakness
- ☐ Seizures

Skin

- ☐ Itching
- ☐ Yellowing of eyes or skin
- ☐ Rash

Hematology/Lymphatic

- ☐ Easy bruising
- ☐ Prolonged bleeding
- ☐ Swollen glands / Nodes

Endocrine

- ☐ Cold intolerance
- ☐ Excessive thirst
- ☐ Heat intolerance

Psychiatric

- ☐ Anxiety
- ☐ Depression
- ☐ Hallucinations
- ☐ Trouble sleeping

Other

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

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Consent & Contact Authorization

Patient Name: _____ Date of Birth: _____

Insurance release/assignment of benefit/payment authorization:
Your fee for service is due and payable by cash, check, credit card, or debit card at the time of treatment. We may not participate in all insurance plans and if your plan is one in which we do not participate, please ask for an office receipt so you can file for reimbursement if applicable. Regardless of any insurance, the guarantor listed on the Patient Information Form is responsible for his/her bill. The guarantor will also be responsible for all charges incurred by collection agencies or past due accounts.

Entities that we may share your health information with when necessary to your treatment, continuity of care, and processing of insurance claims:

Individual Insurance Companies	Billing Services	Providers Associated with Care
Hospital Lab and Ancillary Departments	Electronic Medical Record Software Company	Agencies Associated with Care

Approved Contacts:
List any person(s) who we may speak to regarding your health information or that we may obtain your health information from, including family members, relatives, significant others:

Contact Name	Relationship to Patient	Contact Phone Number

By signing below, you are signifying that you understand and agree to the office and financial policies and the information regarding financial responsibility contained in this New Patient Packet. You are also agreeing to the release of your health information to the above listed entities for the purposes outlined and to the person(s) listed on this form. This listed of designated people can be updated at any time.

Patient Signature: _____ Date: _____

Guardian/POA Signature: _____

Date: _____ Relationship to Patient: _____