Digestive Disease Associates

PATIENT INFORMATION FORM: OPEN ACCESS COLONOSCOPY QUESTIONNAIRE

Name_____
Address:_____
City_____ State_____Zip Code_____
Telephone (daytime) _____Mobile_____
Height_____Weight_____**BMI (*office use only)** _____
Date of Birth_____Primary Care Physician_____
Insurance Carrier_____Member ID #_____
Group #_____Insured Name_____Date of Birth_____
Relationship_____ ___ ___Self Pay_____ No Insurance_____
Allergies:
Eggs?_____Soy?_____Latex?_____
Medication Allergies?_____
_____

Please CIRCLE the appropriate answer for each question (*answers are in bold*):

***Gastrointestinal History**

- What is the reason for your colonoscopy? **Screening Exam** (*no prior colonoscopy in last 10 years*); **Family History of colon cancer**; or **Personal History of Polyps**
- Have you had a previous colonoscopy? **Yes/No**; if yes, what was the date of the exam and what was found?_____
- Do you have a family member with colon polyps who is less than 60 years old? **Yes/No**
- Do you have a family member with colon cancer who is less than 60 years old? **Yes/No**
- Are you having significant lower gastrointestinal symptoms such as: Rectal bleeding? **Yes/No**; chronic diarrhea? **Yes/No**; chronic abdominal pain? **Yes/No**

***Anesthesia**

- Had a heart attack or stroke within the last 6 months? **Yes/No**
- Within the last 6 months have you received any treatment for heart pain (*angina*)? **Yes/No** breathing problems (*COPD*)? **Yes/No** or congestive heart failure? **Yes/No**
- Problems with: Sedation/anesthesia **Yes/No** Opening your mouth or breathing tube **Yes/No**
- Have a defibrillator? **Yes/No** pacemaker? **Yes/No**
- Do you have obstructive sleep apnea? **Yes/No** Use CPAP nightly? **Yes/No**

Yes No Had a coronary (*heart*) or vascular stent within the last year?
Yes No Are you on a blood thinner (*anticoagulant*)? Why?_____
Yes No Are you able to move your neck with good range of motion (*move side to side/up and down*)?
Yes No Are you on oxygen at home during the day or night?

***Current Medication Dosage**

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10._____
11._____
12._____
13._____

Please return this completed 2 page form to our office. If there are no contraindications, you will be assigned to one of our physicians to be set up for a colonoscopy. *You may need an appointment if there are medical concerns that need to be addressed prior to scheduling your colonoscopy.

Digestive Disease Associates

PATIENT INFORMATION FORM: OPEN ACCESS COLONOSCOPY QUESTIONNAIRE

Please CIRCLE all conditions that apply to you

Name_____ **Date of Birth**_____

Gastrointestinal

- Colon cancer
- Colon polyps
- Diverticulosis
- H. Pylori Infection
- Barrett's Esophagus
- Crohn's Disease
- History of ulcer
- Ulcerative Colitis
- GERD/Heartburn
- Hiatal Hernia
- Hemorrhoids
- Intestinal surgery
- Diarrhea
- Constipation
- Blood in bowel movement

Cardiovascular

- Valvular heart disease
- Artificial heart valve
- Angina (Chest pain)
- Hypertension (high blood pressure)
- Heart Attack/MI
- Coronary Artery Disease
- Congestive Heart Failure
- Pericarditis
- Arrhythmia (irregular heart rhythm)
- Peripheral vascular disease
- Chest pain
- Fainting/Black outs

Diabetes/Thyroid

- Insulin dependent diabetes
- Non-insulin dependent diabetes
- Hyperthyroid
- Hypothyroid

Infectious Diseases

- HIV
- Hepatitis B
- Hepatitis C
- AIDS

Respiratory

- Emphysema
- Asthma
- COPD
- Obstructive Sleep Apnea
- Shortness of breath

Kidney Disease

- Chronic kidney disease
- End stage kidney disease
- Hemodialysis
- Peritoneal dialysis
- Fluid restricted
- Diet restricted

Liver Problems

- Cirrhosis
- Fatty Liver
- Elevated Liver Tests

Bleeding Disorders

- Hemophilia
- Other_____

Psychiatric

- Anxiety
- Depression
- Dementia
- Alzheimer's
- Bipolar
- Schizophrenia
- Mood Disorder

Neurological

- Seizure
- Stroke/mini stroke
- Epilepsy

Muscular

- Multiple Sclerosis
- Cerebral Palsy

Past Surgeries (List below)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Social History

- Alcohol Socially _____ Daily_____
- Opioids
- Cocaine
- Marijuana
- Other _____

Tobacco

- Never smoker
- Former smoker
- Current Smoker How much?_____

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DIGESTIVE DISEASE ASSOCIATES

PATIENT INFORMATION					
First Name	M.I.	Last Name	Date of Birth	Age	Sex M F
Street Address		City		State	Zip Code
E-Mail Address		Primary Contact #		Secondary Contact #	
SSN	Marital Status	Single Married Divorced Widowed			

Current Employer		
Employer Name and Address		Phone Ext.
Primary Insurance	Policy Holder	ID#
Secondary Insurance	Policy Holder	ID#

Guarantor Information						
First Name	M.I.	Last Name		Date of Birth		Sex M F
Street Address	City	State	Zip Code	Primary Contact #	Secondary Contact #	
SSN	Employer					

Emergency Contact					
First Name	M.I.	Last Name	Relationship to Patient		Sex M F
Street Address	City State		Zip Code	Primary Contact #	Secondary Contact #

Demographics	
Please Circle Your Race	Black/African American Asian Hawaiian/Pacific Islander White Other
Please Circle your Ethnicity	Hispanic/Latino Not Hispanic/Latino Other
Preferred Language	

Preferred Pharmacy	
Primary Pharmacy Name	Phone Number
Referring Physician	**Primary Care Physician**

Financial Responsibility and Assignment of Insurance Benefits: I guarantee payment to **Digestive Disease Associates** for all charges for services provided to the patient. I understand I am personally responsible for all charges not covered by insurance. I authorize payment of medical benefits, which would otherwise be payable to me, to **DDA.**

Consent for Release of Medical Information: I consent to the use and disclosure of protected health information about me for treatment, payment and healthcare operations. I have read this form. I have had the opportunity to ask questions and my questions have been answered.

Acknowledgement of Receipt of Joint Notice of Privacy Practices: I have received a copy of **DDA** Notice of Privacy Practices.

Signature of Patient or Authorized Person	Date	Time
Staff Signature	Date	Time

DIGESTIVE DISEASE ASSOCIATES OF YORK COUNTY, P.A.
STEPHEN J. BOTT, M.D.
RANDOLPH L. RODRIGUE, M.D.
LARRY H. PENNINGTON, M.D.
SCOTT C. RICHARDSON, M.D.
BRET M. GARRETSON, M.D.
NIRAV N. PATEL, M.D.
170 AMENDMENT AVE.
ROCK HILL, SC 29732

TELEPHONE 803-324-7607
FAX 803-324-4097

Please list the names of anyone that you are giving authorization to obtain your medical information. For example (spouse, family members, friends etc.)

Name	Relationship to patient
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

Patient Signature **Date**

Digestive Disease Associates of York County, P.A.

Notice of Privacy Practices

Effective April 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

Understanding your medical record/health information
As your healthcare provider, we will maintain a record of your visit tnat contains your symptoms, reports of examination, test results, diagnoses, treatments, correspondence with other providers and plans for future care of treatment.

Your health information rights
Your health records is the physical property of this practice, however, the information it contains belongs to you. You have the following rights and we request that you notify the Privacy Office of the Practice of your requests for any of these actions:

A. You have the right to request that we amend your health information.
B. You have a right to inspect and receive a copy of your health information. If you request a copy of your information, you may be charged a reasonable fee for photocopying, retrieval, labor, postage and supplies used.
C. You have the right to request restriction on the use of your information.
D. You have the right to receive a paper copy of this notice.
E. You have the right to request an account of certain disclosures of information that have been made about you. This listing includes disclosures of your information for others for treatment, payment of healthcare purposes and is within a specified period of six years. The first listing of disclosures is provided at no charge and a reasonable fee will be charges for any additional copies within a twelve-month period.
F. You have the right to request that you receive communications regarding your information in a certain manner or a certain location.
G. You have the right to revoke any authorizations for disclosure.

It is the responsibility of our practice to:

A. Maintain the confidentiality and protect the privacy of your health information.
B. We will make available to you a copy of notice explaining our legal duties and privacy practices.
C. We will abide by the terms of this notice.
D. We will notify you if we are unable to agree with a request to restrict information.
E. We will accommodate reasonable requests that you make in order to communicate health information by alternative means or at alternative locations. We reserve the right to change our privacy practices and will notify you of any changes as you return to our office.

Our office will disclose information for the following reasons:

We will disclose health information for treatment purposes, payment, and other healthcare operations.

Treatment:
We will disclose your health information for treatment purposes and will provide your other healthcare providers with copies of various reports that will help them in any treatment needs that may arise.

Payment:
We may send a copy of a bill for payment to you or any third party payers. We will also furnish third party payers with any information necessary in order to process payment. This information may include medical records, diagnosis, information identifying you etc.

Business Associates:
There are some services provided through contracts with business associates. When those services are contracted, we may disclose your health information to this business associate so that they can perform the work we require. To protect your health information, the business associates must appropriately safeguard your information.

Notification:
We may disclose information to notify or assist in notifying a family member, personal representative or other person responsible for your care, information about your general condition.

Research:
We will disclose only limited information to approved researchers that participate in research approved by our institutional review board. We will obtain a written authorization from you to disclose information for other research purposes.

Funder Directors:
We may disclose health information to funeral directors consistent with state law that allows them to carry out their duties.

Organ Donation:
If you are an organ donor, we may disclose your information to organizations that help procure, bank or transport organs for tissue donation and transplantation procedures.

Marketing:
We may contact you to provide appointment reminders or information about health related benefits and services that may be of interest to you, and leave messages on your answering machines.

Fund raising:
We may contact you as a part of a fund-raising event.

Food and Drug Administration:
We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post-marketing surveillance information to enable produce recalls repairs or replacement.

Workers compensation:
In accordance with state law, we may disclose health information as is required for processing a claim under worker's compensation.

Public Health:
Under South Carolina law, we may disclose your health information to the health department in order to prevent or control disease injury or disability.

Health investigation:
Federal and state laws make provisions for your health information to be released appropriate health authorities provided that a member of our staff or business associates believes in good faith that we have engaged in lawful conduct or have otherwise endangered on or more patients, workers or the public.

Other disclosures:
Other uses and disclosures of your information will only be made with written authorization. I you have authorized us to use or disclose information about you, you may revoke this authorization at any time.

Questions and Complaints:
If you would like more information about or privacy practices or have questions or concerns, please contact us.
If you are concerned that we may have violated your privacy rights, please contact our office.
803-324-7607