Philadelphia Gastroenterology Consultants, Ltd.

Date _____

Dear _____;

An appointment has been scheduled for you to see _____

on _____at_____.

1. **PLEASE ARRIVE PROMPTLY FOR YOUR APPOINTMENT. CANCELLATIONS MUST BE MADE 24 HOURS IN ADVANCE OF YOUR APPOINTMENT OR A $25 FEE WILL BE APPLIED.**

2. Please fill out the medication list by reading the labels on your prescription bottles and filling in the form, or bring the actual medication bottles if you have trouble.

3. Please bring all recent (within 6months) blood test results, x-ray results (CT scan, ultrasound, MRI, etc) or other test related to your problem with you on the day of your appointment. If you do not have these tests available at the time of your appointment, our doctors may not be able to fully evaluate you.

4. Please fill out the enclosed information sheets ahead of time and bring them with you, along with your insurance card and a form of photo ID. This will save you time from waiting to be taken into an exam room.

5. If you have HMO insurance, you must have a referral from your primary physician or you will not be able to be seen.

6. All co-pays are due at the time of your office visit. Our office reserves the right to reschedule your appointment if co-pay is not paid.

7. In the event you do not have any insurance, you will be expected to pay for your service in full at the time of your appointment. Any questions or concerns you may have about payment can be directed to the billing department before your appointment.

8. We look forward to seeing you and will do everything possible to make your visit comfortable and pleasant.

PLEASE ARRIVE 30 MINUTES EARLY FOR YOUR APPOINTMENT SO THAT WE MAY COLLECT AND PROCESS ALL OF YOUR INFORMATION

700 Cottman Ave ♦Bldg. B ♦ Suite 201 ♦ Philadelphia, PA 19111
Phone: (215) 742-9900 ♦ Fax: (215) 742-7051 ♦Website: www.pgcdocs.com

Philadelphia Gastroenterology Consultants, Ltd.
PGC Endoscopy Center for Excellence, LLC
700 Cottman Avenue ~ Bldg B Suite 201 ~ Philadelphia, PA 19111 ~ Phone 215-742-9900 ~ Fax 215-742-7051

Patient Information Form

Please PRINT all information
Date: _____

Last Name _____ **First Name** _____ **MI** _____

Date of Birth _____ **Age**_____ **Social Security Number** _____

Street Address _____

City _____ **State** _____ **Zip Code** _____

Home Phone _____ **Cell Phone** _____ **Work Phone** _____

Are you currently employed? YES NO

Circle one: Sex M F Marital Status: S M D W

Circle one: Ethnicity: Hispanic or Latino Not Hispanic or Latino Race: _____ **Language**_____

Email Address _____@_____

Local Pharmacy _____ **Local Pharmacy Phone** _____

Mail Order Pharmacy _____ **Mail Order Pharmacy Phone**_____

Emergency Contact_____ **Phone**_____

Emergency Contact Relationship to the Patient _____

Primary Care Provider _____ **Phone**_____

Referring Provider_____ **Phone**_____

Insurance Information

Primary Insurance and Address_____

Name of Subscriber _____

Policy ID# _____ **Group#** _____

Secondary Insurance and Address _____

Name of Subscriber _____

Policy ID# _____ **Group#** _____

Reviewed for accuracy:_____

Philadelphia Gastroenterology Consultants, Ltd.
PGC Endoscopy Center for Excellence, LLC

BILLING CONSENT

I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance, if the Practice/Center does not participate with my insurance.

I agree to pay all co-payment, co-insurance and deductibles at the time the service is rendered.

I hereby authorize release of medical information by Philadelphia Gastroenterology Consultants, Ltd and/or PGC Endoscopy Center for Excellence, LLC to my insurance Company.

I hereby assign all medical and/or surgical benefits, including major medical benefits, Medicare and commercial insurance to Philadelphia Gastroenterology Consultants, Ltd. or PGC Endoscopy Center for Excellence, LLC.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

_____ _____

Signature of Patient or Guardian *Date*

_____

If Guardian, Name and Relationship to Patient

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY

I, _____, whose signature appears below, authorize Philadelphia Gastroenterology Consultants, Ltd and PGC Endoscopy Center for Excellence, LLC and its Affiliated Providers to view my external prescription history via our electronic medical record system, eClinicalWorks.

I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and authorized staff here, and it may include prescriptions back in time for several years.

MY SIGNATURE CERTIFIES THAT I HAVE READ AND UNDERSTAND THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THIS ACCESS.

_____ _____

Signature of Patient or Guardian *Date*

_____

If Guardian, Name and Relationship to Patient

Philadelphia Gastroenterology Consultants, Ltd.
PGC Endoscopy Center for Excellence, LLC

PATIENT HISTORY FORM

Date:_____

PATIENT NAME _____ DOB _____
(as it appears on your insurance card)

Reason for your visit: _____

_____

Referring Provider: _____

Primary Care Provider: _____

Other Providers You Are Seeing: _____

_____

Local Pharmacy: _____ Phone Number: _____

Mail Order Pharmacy: _____

Current Medications (including over-the-counter, vitamins and herbal supplements)

Name	Dose	Frequency

Name	Dose	Frequency

PATIENT NAME _____ **DOB** _____

Past Medical Illnesses

☐ None
☐ Alzheimer's
☐ Anemia
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Back pain
☐ Blood transfusion
☐ Breast Cancer
☐ Chronic lung disease
☐ Cirrhosis of liver
☐ Colitis
☐ Colon cancer
☐ Colon polyps
☐ Crohn's disease
☐ Depression
☐ Diabetes
☐ Diverticulitis
☐ Diverticulosis
☐ Emphysema
☐ Esophageal cancer
☐ Frequent urinary infections
☐ Gallstones
☐ Glaucoma
☐ Gout
☐ Heart attack
☐ Heart murmur
☐ Hepatitis ☐A ☐B ☐C
☐ Hiatal hernia
☐ High blood pressure
☐ High cholesterol
☐ High Triglycerides
☐ HIV/AIDS
☐ Irregular heart beat
☐ Irritable bowel syndrome
☐ Kidney disease
☐ Kidney failure
☐ Kidney stones
☐ Lactose intolerance
☐ Liver Cancer
☐ Osteoporosis
☐ Pancreatitis
☐ Paralysis
☐ Parkinson's
☐ Pneumonia
☐ Prostate cancer
☐ Reflux
☐ Rheumatic Fever
☐ Seizures
☐ Skin Cancer
☐ Stroke
☐ Tuberculosis
☐ Thyroid disease
☐ Ulcer
☐ Ulcerative colitis
☐ _____
☐ _____
☐ _____
☐ _____
☐ _____

Allergies

☐ None ☐ Aspirin ☐ Codeine ☐ Demerol ☐ Iodine ☐ Morphine ☐ Penicillin
☐ Sulfa ☐ Valium ☐ Latex ☐ _____ ☐ _____

Previous Surgeries and Year Performed

☐ None	☐ Hemorrhoids	☐ Prostate
☐ Appendectomy	☐ Hiatal hernia repair	☐ Stomach
☐ Breast biopsy	☐ Hip replacement	☐ Sterilization
☐ Cardiac Bypass	☐ Hysterectomy	☐ Thyroid surgery
☐ Cholecystectomy (gallbladder)	☐ Kidney	☐ Tonsillectomy
☐ Colon resection	☐ Knee surgery	☐ Vascular surgery
☐ Colostomy	☐ Lung surgery	☐
☐ C-section x____	☐ Mastectomy	☐
☐ Groin hernia x ___	☐ Obesity surgery	☐
☐ Heart valve replacement/repair	☐ Ovaries/Tubes	☐

Past Gastrointestinal Examinations

Procedure	Results	Date of Exam	Performed by
Colonoscopy			
Upper Endoscopy			
Capsule Endoscopy			
Sigmoidoscopy			
ERCP			
Liver biopsy			

PATIENT NAME _____ **DOB** _____

FAMILY HISTORY

	Mother	Father	Brother(s)	Sister(s)	Children	Grandparents
Deceased						
Alcoholism						
Anemia						
Bleeding tendency						
Breast Cancer						
Colon Cancer Age at diagnosis						
Colon polyps						
Crohn's disease						
Depression						
Diabetes						
Esophagus cancer						
Heart problems						
Hepatitis						
High blood pressure						
Liver cancer						
Liver disease						
Lung cancer						
Lung disease						
Pancreatic cancer						
Stomach cancer						
Stroke						
Thyroid disease						
Ulcer						
Ulcerative colitis						
Weight problems						
Other cancers (type)						

Tobacco

☐ I have never used tobacco products ☐ I quit using tobacco _____years ago.

☐ I smoke ____packs a day for _____years. ☐ I use chewing tobacco

Alcohol

☐ Never ☐ Rarely

☐ ___ drinks per day

☐ In recovery

Recreational Drug Use

☐ Never ☐ Currently

☐ Injected

☐ In recovery

Tattoos

☐ Professionally placed

☐ Non-professionally

How many_____

Social History

☐ Blood transfusion_____ When_____☐ Children How many?_____

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Long term partner

☐ Occupation_____

PATIENT NAME _____ **DOB** _____

Have you ever tested positive for MRSA? (please circle) YES NO

If yes, when were you diagnosed?_____

Review of Systems

Gastrointestinal

☐ None	☐ Changes in bowels	☐ jaundice	☐ Leakage of stool
☐ Abdominal pain	☐ Dairy Intolerance	☐ Loss of appetite	☐ Vomiting
☐ Belching	☐ Diarrhea	☐ Mucus in stool	☐ Stool urgency
☐ Black stools	☐ Difficulty swallowing	☐ Nausea	☐
☐ Bloating	☐ Flatulence (gas)	☐ Pain with moving bowels	☐
☐ Constipation	☐ Hemorrhoids	☐ Rectal bleeding	☐

General/Constitutional	**Pulmonary/Lung**	**Urinary/Renal**
☐ None	☐ None	☐ None
☐ Chills	☐ Cough	☐ Frequent urination
☐ Fever	☐ Shortness of breath	☐ Blood in urine
☐ Headache	☐ Wheezing	☐ Dialysis
☐ Lightheadedness	☐ Use of oxygen	☐
☐	☐ Use of CPAP	**Musculoskeletal**
Eyes	☐	☐ None
☐ None	**Cardiovascular**	☐ Joint swelling
☐ Visual Decline	☐ None	☐ Muscle aches
☐ Blindness	☐ Chest pain	☐ Back Pain
☐	☐ Shortness of breath	☐
Ears, Nose and Throat	☐ Ankle swelling	**Skin**
☐ None	☐	☐ None
☐ Post nasal drip	**Hematologic**	☐ Rash
☐ Allergies	☐ None	☐ Bruising
☐ Canker sores	☐ Easy bruising	☐ Itching
☐ Loss of dental enamel	☐ History of clotting problems	☐
☐ Hoarseness	**Female**	**Neurologic**
☐ Hearing loss	☐ None	☐ None
☐	☐ Heavy menses	☐ Dizziness
Endocrine	☐ Menopause	☐ Frequent headaches
☐ None	☐	☐
☐ Swollen glands	**Male**	**Psychiatric**
☐	☐ None	☐ None
	☐ Testicular/scrotal prob.	☐ Anxiety
	☐	☐ Depression
		☐ Panic attacks
		☐ Sleeping difficulty
		☐

Philadelphia Gastroenterology Consultants, Ltd.

PATIENT NAME: _____

Have you undergone recent diagnostic testing?

1. CT Scan	Yes	No	Where_____	When _____
2. MRI	Yes	No	Where_____	When _____
3. Bloodwork	Yes	No	Where_____	When _____
4. Upper GI Series	Yes	No	Where_____	When _____
5. Barium Enema	Yes	No	Where_____	When _____
6. Ultrasound	Yes	No	Where_____	When _____
7. Colonoscopy	Yes	No	Where_____	When _____
8. Upper Endoscopy (EGD)	Yes	No	Where_____	When _____
9. Stool Studies	Yes	No	Where_____	When _____
10. Other Testing	Yes	No	Where_____	When _____

New Patients If you have answered YES to any of the above, please bring copies of ALL reports on the day of your visit. Thank you.

Name of Patient (Please Print) _____ Date of Birth _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I received the Notice of Privacy Practices for **Philadelphia Gastroenterology Consultants, Ltd** and **PGC Endoscopy Center for Excellence, LLC**

I request that you attempt to contact me with confidential communications about my healthcare in the following way(s):

Leave messages on home answering machine? Yes □ No □ Phone # _____

Leave message on voicemail at place of employment? Yes □ No □ Work # _____

Leave messages on cell phone? Yes □ No □ Cell # _____

Email? Yes □ No □ Email address _____

Discuss my healthcare with family members? (Please specify names)

_____

Additional instructions _____

_____

This request will remain in effect unless otherwise revoked writing

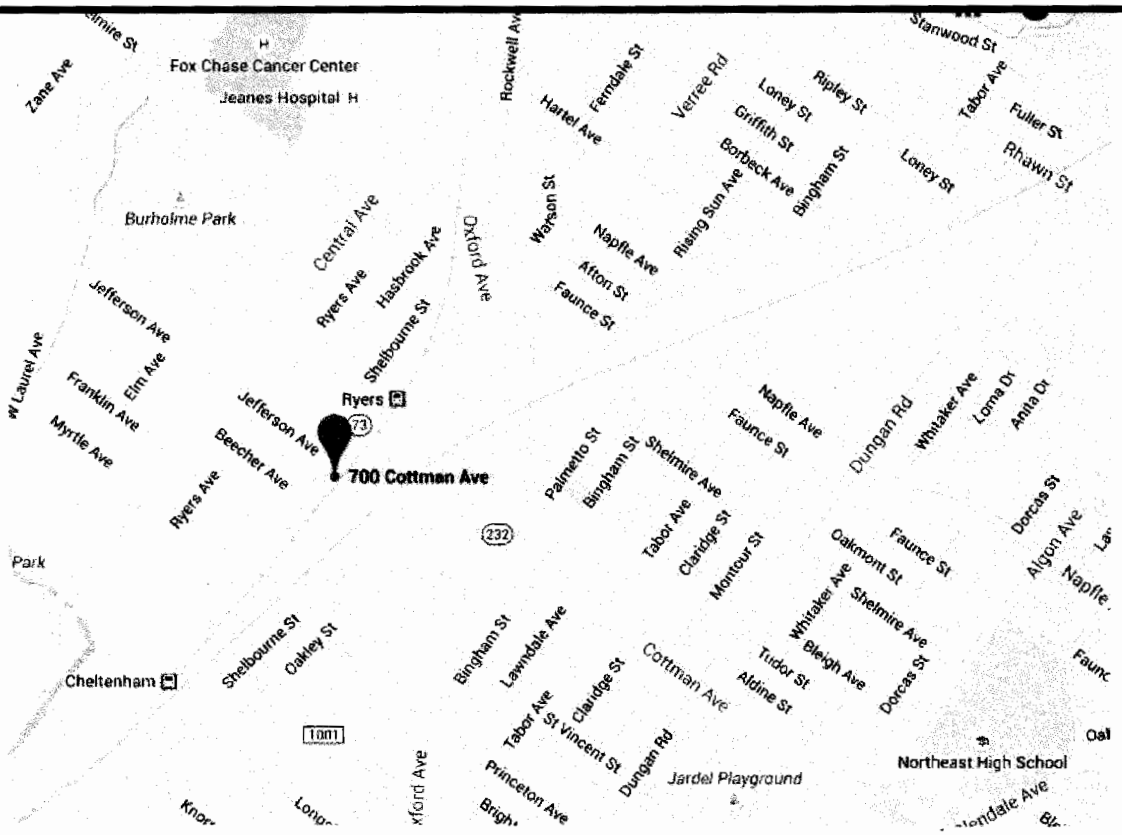
_____ _____

Signature of Patient or Personal Representative Date

_____ _____

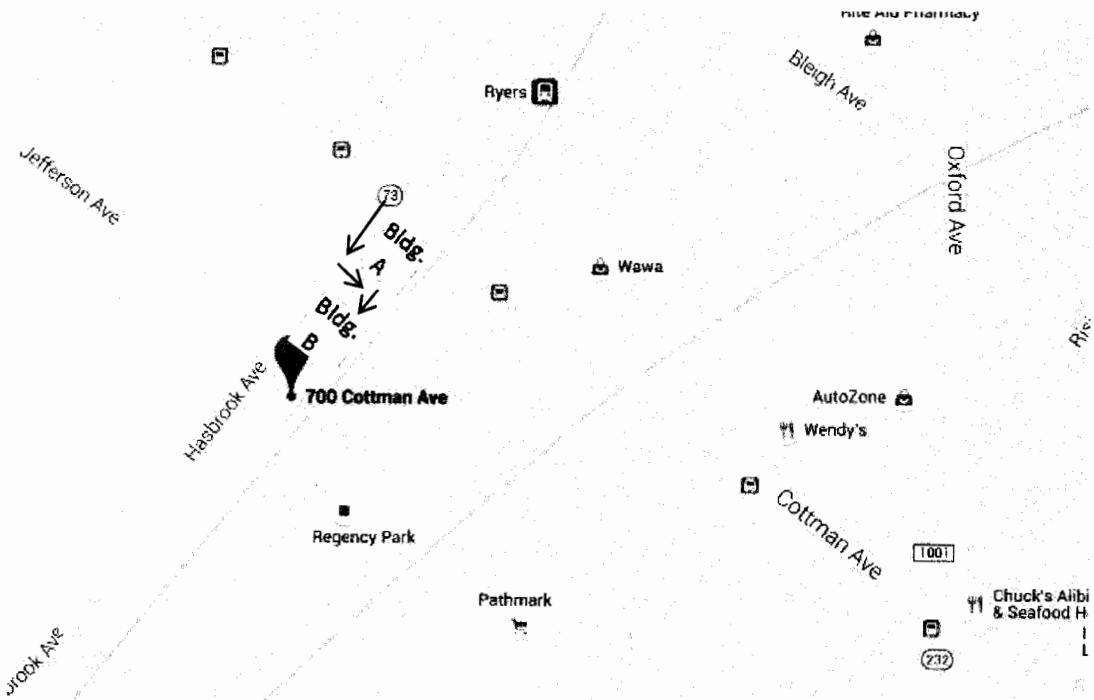
Print Name of Personal Representative Relationship to Patient

Philadelphia Gastroenterology Consultants, Ltd. & PGC Endoscopy Center for Excellence, LLC



Our Address is 700 Cottman Ave Suite 201 in Building B

Our parking lot and office entrance is located off of Hasbrook Avenue



700 Cottman Avenue ♦ Bldg. B Suite 201 ♦ Philadelphia, PA 19111
Phone: (215) 742-9900 ♦ Fax: (215) 742-7051 ♦ Website: pgcdocs.com