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 $50 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. Please give your primary physician our **NPI # 1861425613**

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.

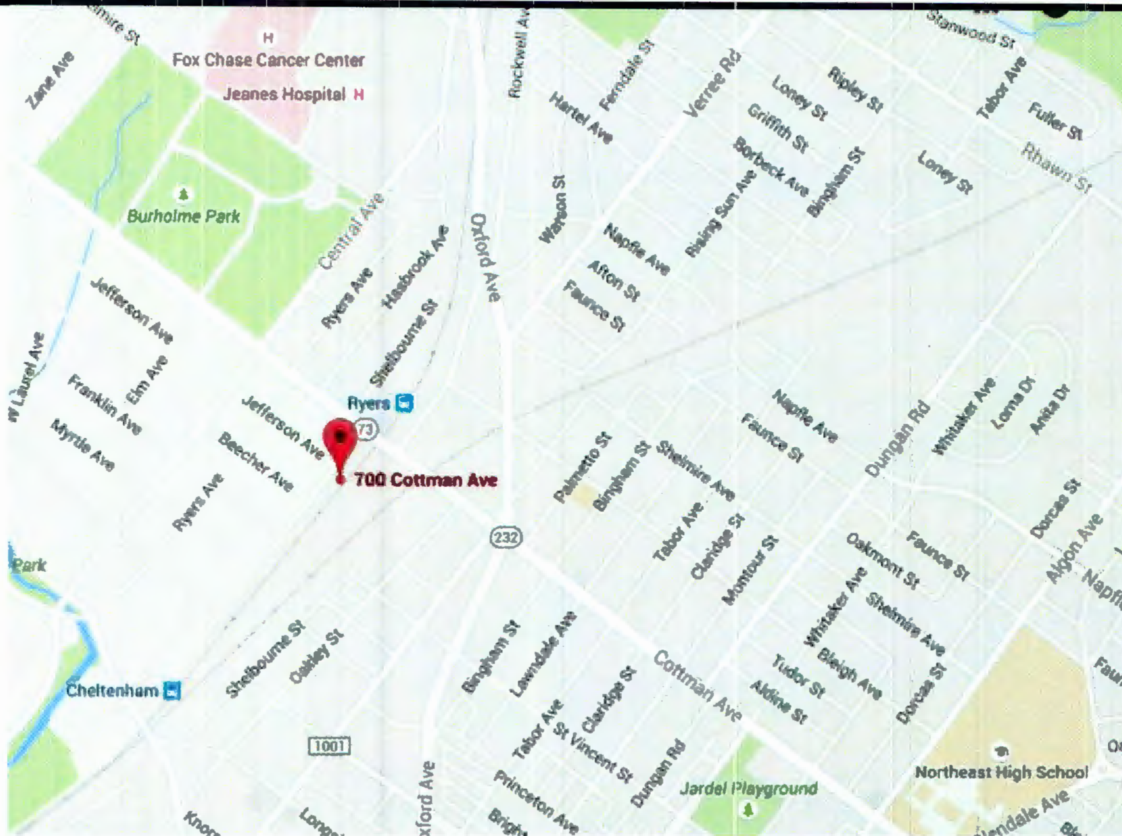
7. In the event you do not have any insurance, you will be expected to pay for your service in full at the time of your appointment. Any questions or concerns you may have about payment can be directed to the billing department before your appointment.

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

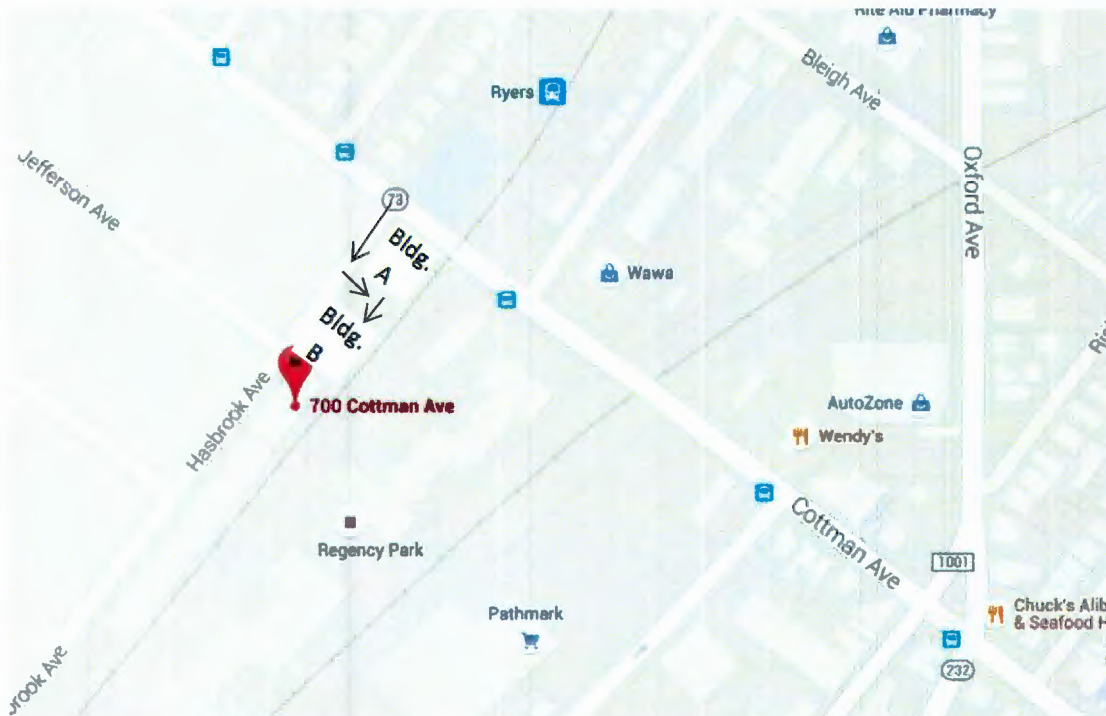
700 Cottman Ave ♦Bldg. B ♦ Suite 201 ♦ Philadelphia, PA 19111
Phone: (215) 742-9900 ♦ Fax: (215) 742-7051 ♦Website: www.pgcdocs.com

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



Our Address is 700 Cottman Ave Suite 201 in Building B

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



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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:________________

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

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

Sent to:______________________________ Date:__________

Philadelphia Gastroenterology Consultants, Ltd.

Authorization for Release of Information

I hereby authorize Philadelphia Gastroenterology Consultants, LTD to obtain the following information: any medical records or other information regarding my treatment, hospitalization, and/or outpatient care for my impairment(s), Hepatitis C, drug abuse, alcoholism, or human immunodeficiency virus (HIV) infection, including acquired immunodeficiency syndrome (AIDS), or testing for HIV; from the health record(s) of:

Patient Name:______________________ D.O.B. __________ MR#: ________

Hospital Adm. Date: ____________________ D/C Date: ____________________

Hospital Out-pt. Date: ____________________ ED Date: ____________________

Information to be released (Check all that apply):

(__) Discharge Summary (__) Radiology Report

(__) History & Physical (__) Operative Report

(__) Laboratory report (__) Pathology Report

(__) Consultation Report (__) All GI Records

(__) Emergency Record (__) All of the above

(__) Other (Specify): ____________________

Please fax above records to 215-742-7051 as soon as possible.

I understand this consent can be revoked at any time except to the extent that disclosure has already occurred in reliance on this request. Otherwise, this authorization shall remain in effect indefinitely, unless specified by the patient or parent-legal guardian.

____________________, __________ ____________________, __________
Signature of Patient Date Signature of Parent-Legal Guardian Date

____________________, __________
Requesting Provider Staff Initials

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Phone: (215) 742-9900 ♦ Fax: (215) 742-7051 ♦ Website: www.pgcdocs.com

Philadelphia Gastroenterology Consultants, Ltd.

PATIENT NAME: ____

Have you undergone diagnostic testing?

1. CT Scan	Yes	No	Where__________	When _______
2. MRI: Body Part __________	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 _______

11. Have you ever seen another Gastroenterologist? YES / NO
    If yes, name of doctor ____________________________________

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.

****For Office Use Only:*** ____

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____

Immunizations

☐Flu Vaccincation___Yes / No_____When____________
☐Pneumonia Vaccination___Yes / No_____When____________
☐Shingles Vaccination___Yes / No_____When____________
☐Other____

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
		☐