LEHIGH GASTROENTEROLOGY ASSOCIATES LLC
204 STATE ROAD LEHIGHTON, PA 18235
P:610-379-0443 F: 610-379-4725

Gastroenterology

Patient Name:_____

Date of Birth_____ Age:_____ Sex:_____

Social Security Number:_____ Phone:_____Cell:_____

Address:_____

Can we mail information to you yes or no

Patient Employer:_____Occupation:_____

Insurance Information

Please give the receptionist a copy of your cards

Primary insurance:_____Policy #_____

Group#_____Subscriber:_____DOB:_____

Relationship to patient:_____

Secondary Insurance:_____Policy#_____

Group#_____Subscriber:_____DOB:_____

Relationship to patient:_____

Referring Physician:_____Phone:_____

Pharmacy:_____Phone#_____

EMERGENCY CONTACT

Name:_____Phone:_____

Relationship:_____ can we leave a message with this person yes/no

Name:_____Phone:_____

Relationship:_____can we leave a message with this person yes/no

MEDICAL QUESTIONNAIRE

Reason You Were Referred and/or Major Digestive Complaint

_____

_____

Past Medical History Medical Illness

1. Heart Disease Yes No
2. Heart Attack Yes No
3. High Blood Pressure Yes No
4. Diabetes Yes No
5. Lung Disease Yes No
6. Kidney Disease Yes No
7. Caner Yes No
   Type:_____
8. Stroke or Neurological Disease Yes No
9. Blood Disorder Yes No
10. HIV/AIDS Yes No
11. Other:_____

Past Surgical History List Operations and Dates:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Prior Gastrointestinal or Liver Disease

1. Irritable bowel Yes No
2. Ulcer Yes No
3. Cirrhosis Yes No
4. Colon Cancer or Polyps Yes No
5. Have you ever Seen a gastroenterologist Yes No
   Name and Address: When:

   _____

6. Other:
   _____

Prior Gastrointestinal X-rays/Colonoscopy/Endoscopy

1. What Kind:_____When:_____Where:_____

   Why:_____

2. What Kind:_____When:_____Where:_____

   Why:_____

Medications

1._____ 4._____ 7._____

2._____ 5._____ 8._____

3._____ 6._____ 9._____

Allergies

To Medications:_____

To Intravenous Dye/Iodine/Shellfish/latex/eggs:_____

Family Medical History

(G.I. Illnesses,stomach,liver,colon or gallbladder)

1._____ 3._____

2._____ 4.Colon Cancer or Polyps Yes No

Other Family Illnesses

1._____ 3._____

2._____ 4._____

Travel & Lifestyle

Foreign travel in the past year:_____Tranfusions:_____

Tobacco Usage: Yes No What type/how long:_____

Alcohol Usage: Yes No What type/how long:_____

Aspirin Usage: Yes No

Caffeine Usage: Yes No What type/how much_____

Do you have tattoos Yes No

Do you use Recreational Drugs Yes No/former how much type_____

Female Patients Only

Gynecologic History:_____

Gynecologist:_____

Last visit_____Last Menstrual period(if applicable)_____

Present/prior birth control usage_____

Do You Now Have (circle)

1. RESPIRATORY: Asthma,pneumonia,chronic bronchitis,TB,emphysema,wheezing,shortness of breath, cough.
2. CARDIOVASCULAR: Chest pain, heart attack, valve replacement, palpitations, irregular rhythm, leg swelling.
3. SKIN: Itching, rashes.
4. BLOOD: Anemia,bleeding problems, swollen lymph glands, easy bruising.
5. GENITOURINARY: Bladder or kidney infection, kidney stones, frequent urinations, burning, incontinence,(leakage) blood in urine, difficulty urinating.
6. EMOTIONAL: depression,crying spells, nervousness,trouble sleeping,excessive stress.
7. BONES/JOINTS:Swelling,arthritis,muscle cramps, joint pain, back pain.
8. HEAD: vision change (besides glasses or contacts) inflammation of eyes, sinusitis, nose bleeds, hoarseness, severe gum or dental disease, sore tongue, throat pain.
9. ALLERGIC: hay fever, eczema, food allergies/sensitivities
10. NEUROLOGICAL: Seizures, headaches, or migraines, stroke,numbess/tingling,dizziness
11. ENDOCRINE: Diabetes,thyroid disease.
12. CONTITUTIONAL: weight loss or gain. Fever, chills, night sweats, fatigue, weakness
13. GASTROINTESTINAL: Loss of appetite, excessive belching or flatus(gas) nausea, vomiting, regurgitation,heartburn,trouble or pain with swallowing,abdominal pain,diarrhea,constipation,change in bowel habits,rectal bleeding, vomiting blood,bloating,use of laxatives, jaundice.

I acknowledge that all information is correct and I have received and read all Lehigh Gastroenterology's financial policy and HIPPA policy and accept financial responsibility for myself/dependent for services provided.

Signature:_____ **Date:**_____

Relationship if not the patient:_____

Lehigh Gastroenterology Associates

Insurance Authorization Form

O Medicare#_____

Statement to permit payment of Medicare benefits to provider, physicians and patient

I request payment of authorized Medicare benefits to me or on my behalf for any other services furnished to me by Lehigh Gastroenterology Associates. I authorize any holder of medical and other information about me to release to the health care financing administration (Medicare) and its agents any information needed to determine benefits or benefits for related services. I understand that I am responsible for any health insurance deductibles, co-insurance or other non-covered services.

Date:_____ Signature of Beneficiary_____

Date:_____ other Signature_____

Relationship_____

O Medigap#_____

I request that payment of authorized Medigap benefits be made either to me or on my behalf to the provider of services for any services furnished to me by that provider of service and/or supplier. I authorize any holder of Medicare information about me to release to (name of Medigap Insurer)_____ any information needed to determine these benefits payable for related services.

Date:_____ Signature of Beneficiary_____

Date:_____ Other Signature_____

Relationship_____

O Medical Assistance#_____

My signature certifies that I received a service or item on the date listed below. I understand that payment for services or items will be from Federal and state funds and that any false claims, statements or documents or concealments of materials may be prosecutes under applicable federal and state laws.

I have read and agree with the above statement.

Date:_____ Signature:_____

O Commercial Insurance_____

Assignment of benefits: I hereby assign to LGA an authorize and direct that payment be made directly to LGA all benefits otherwise payable to me directly under the terms of my insurance policies (including major medical) by reason of the services described in the statements rendered by LGA, provide that LGA shall refund to the person or persons entitled to receive the same, any payments in excess of its full charges. I have received and read LGA's financial policy and understand I am financially responsible for all charges not covered by this assignment.

Date:_____ Signature:_____

Lehigh Gastroenterology FINANCIAL POLICY

It is the policy of Lehigh Gastroenterology to have a Financial Policy that clearly outlines patient and practice responsibilities. We are committed to providing our patients with the best possible medical care while minimizing administrative costs. This policy has been developed with these objectives in mind, and to avoid any misunderstandings or disagreements concerning payment for professional services.

Please read the following carefully:

For patients who do not have insurance:

Patients who do not have any insurance coverage are expected to pay for services rendered at the time of the visit. Payment plans are available for patients who need, please contact the office manager.

For patients who are currently covered by insurance:

The patient is responsible to provide us with valid health insurance information, and should bring their insurance card to each visit. Our office participates with numerous insurance companies and managed health care programs. For patients that are members of one of these plans, our office will submit a claim for services using a standard CMS 1500 claim form. Our office bills secondary insurances as a courtesy to our patients.

If you have a plan that our practice participates with:

The patient is responsible to pay any co payment or any portion of the charges as specified by the plan at the time of the visit. Any medical service not covered by an individual's insurance plan is the patient's responsibility and payment in full is due at the time of the visit. Specified coverage issues should be addressed with the insurance company's member services department (telephone number is on the insurance card).

If you have a plan our office <u>does not</u> participate with:

If the patient has insurance that we <u>do not participate in,</u> our office will file a claim upon request, but payment is expected at the time of service.

If you are covered by and HMO or Managed Care Plan:

The patient is responsible to pay any copay or any portion of the charged as specified by the plan at the time of the visit. The patient is responsible to ensure that any required referral for treatment is provided to the practice at the time of the visit. Non-emergent visits may be rescheduled or the patient may be financially responsible due to the lack of the referral.

Other:
The office reserves the right to charge for the completion of forms. For example, insurance, disability, medication, and copying of records.

Signature:_____ **Date:**_____