

**NORTHSIDE GASTROENTEROLOGY-CONFIDENTIAL PATIENT REGISTRATION**

Please Print

NAME: \_\_\_\_\_ DOB \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
HOME PHONE: (\_\_\_\_) \_\_\_\_\_ Marital status M S W D Social Security # \_\_\_\_\_  
EMPLOYER: \_\_\_\_\_ WORK PHONE (\_\_\_\_) \_\_\_\_\_  
PRIMARY INSURANCE: \_\_\_\_\_  
SECONDARY INSURANCE: \_\_\_\_\_  
NEXT OF KIN & RELATIONSHIP: \_\_\_\_\_

REFERRING DOCTOR \_\_\_\_\_ REASON FOR REFERRAL \_\_\_\_\_

**Personal Symptoms or Problems:**

Please check if these pertain to you:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Abdominal pain            | <input type="checkbox"/> Diverticulosis/Diverticulitis | <input type="checkbox"/> Recent Wt. Change                |
| <input type="checkbox"/> Anemia                    | <input type="checkbox"/> Emphysema                     | <input type="checkbox"/> Loss/Gain _____ lbs.             |
| <input type="checkbox"/> Artificial Heart Valve    | <input type="checkbox"/> Family Hx Colon Cancer        | <input type="checkbox"/> Rectal Bleeding                  |
| <input type="checkbox"/> Arthritis/Art Joints      | <input type="checkbox"/> Fevers                        | <input type="checkbox"/> Rectal Pain                      |
| <input type="checkbox"/> Asthma/Bronchitis         | <input type="checkbox"/> Frequent nose bleeds          | <input type="checkbox"/> Seizures                         |
| <input type="checkbox"/> Barrett's Esophagus       | <input type="checkbox"/> Glaucoma                      | <input type="checkbox"/> Short of breath at rest/exercise |
| <input type="checkbox"/> Bleed Easily              | <input type="checkbox"/> Heart trouble of any kind     | <input type="checkbox"/> Sores in mouth                   |
| <input type="checkbox"/> Blood/Tar Like Stool      | <input type="checkbox"/> Heart Murmur                  | <input type="checkbox"/> Stroke                           |
| <input type="checkbox"/> Blood thinner use         | <input type="checkbox"/> Heartburn/Acid Reflux/GERD    | <input type="checkbox"/> Swallowing trouble               |
| <input type="checkbox"/> Chest pain/Cough          | <input type="checkbox"/> Hemorrhoids                   | <input type="checkbox"/> U/C or Crohn's                   |
| <input type="checkbox"/> Chronic sinus congestion  | <input type="checkbox"/> Hepatitis                     | <input type="checkbox"/> Ulcer of Stomach/Duodenum        |
| <input type="checkbox"/> Colon Cancer/Polyps       | <input type="checkbox"/> Hiatal Hernia                 | <input type="checkbox"/> Vomiting Blood                   |
| <input type="checkbox"/> Constipation Freq.        | <input type="checkbox"/> High Blood Pressure           | <input type="checkbox"/> Other _____                      |
| <input type="checkbox"/> Cough with sputum         | <input type="checkbox"/> Nausea or Vomiting            | <input type="checkbox"/> Other Cancer _____               |
| <input type="checkbox"/> Daily Aspirin/Ibuprofen   | <input type="checkbox"/> Night Sweats                  |   |
| <input type="checkbox"/> Depression/Mental Illness | <input type="checkbox"/> Pacemaker/AICD                |   |
| <input type="checkbox"/> Diabetes/ _____ Accucheck | <input type="checkbox"/> Prolonged hoarseness          |   |
| <input type="checkbox"/> Diarrhea, Recurrent       | <input type="checkbox"/> Rheumatic Fever               |   |

\_\_\_\_\_ Abnormal Liver Blood Tests \_\_\_\_\_ Abnormal GI Tract X-ray or study If Yes, what kind \_\_\_\_\_  
\_\_\_\_\_ Number of years you smoked \_\_\_\_\_ Pack of Cigarettes/day \_\_\_\_\_ Quit Smoking \_\_\_\_\_ Years Ago

Do you drink alcoholic beverages? \_\_\_\_\_ If yes, how much per week \_\_\_\_\_

Do you drink coffee/caffeinated drinks? \_\_\_\_\_ If yes, how much per day \_\_\_\_\_

List any recent x-rays (NOT DENTAL) or scans and where they were done. \_\_\_\_\_

**I request that payment of authorized Medicare/Commercial insurance benefits be made on my behalf to Northside Gastroenterology for any services furnished me by their physicians. I understand that I am fully responsible for those charges not paid by my insurance. I authorize any holder of medical information about me to be released to the health insurance carrier(s) and its agents any information needed to determine these benefits or the benefits payable for related services.**

\_\_\_\_\_  
Signature of patient/guardian

\_\_\_\_\_  
Date

\*\*\*\*\*PLEASE COMPLETE MEDICATION LIST ON OTHER SIDE OF THIS FORM\*\*\*\*\*

