Digestive Disease Consultants

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Welcome to Digestive Disease Consultants. We appreciate you choosing our providers for your healthcare needs.

The Following **COMPLETED FORMS** are all necessary for your upcoming appointment.

Please complete the enclosed packet and bring it with you to your appointment as well as the following:

- A PHOTO ID
- AN ACTIVE MEDICATION LIST
- YOUR MOST CURRENT INSURANCE CARD(S)
- ANY CO-PAYMENT OR INSURANCE DEDUCTIBLE (DUE AT TIME OF SERVICE)

We also need the following information from your referring physician (IF NECESSARY)

- A REFERRAL EITHER WRITTEN OR AUTHORIZATION BY YOU INSURANCE COMPANY
- ALL RECENT LABS REPORT
- ALL RECENT OFFICE NOTES FROM YOUR REFERRING PHYSICIAN TO LET OUR PHYSICIANS KNOW WHY YOUR ARE BEING REFERRED FOR YOUR UPCOMING APPOINTMENT.

Additionally, We request that you kindly give our office 24 hour notice if cancellation is necessary on your part.

Thank you for your cooperation,
Digestive Disease Consultants

APPOINTMENT DATE AND TIME: _____

MAIN OFFICE:	2151 RIVERSIDE AVENUE, JACKSONVILLE, FL. 32204 Phone: 904-388-8686
MIDDLEBURG OFFICE:	1658 ST VINCENT'S WAY, STE 110, MIDDLEBURG, FL. 32068 Phone: 904-406-0633
MEMORIAL OFFICE:	3627 UNIVERSITY BLVD. S, STE 430 , JACKSONVILLE, FL 32216 Phone: 904-858-9700

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PATIENT INFORMATION:

Name_____ SS#_____

Street Address_____ City_____

State_____ Zip_____ DOB_____ Marital Status _____ Gender: Male/Female

Ethnicity: Asian/Pacific Islander African American Caucasian Hispanic Native American Other_____

Home Phone_____ Work Phone_____ Cell Phone_____

Email_____

Patient Employer_____ Phone Number_____

Spouses Name _____Spouse's DOB_____ Employer_____

Emergency Contact_____ Phone_____

Pharmacy Name _____ Phone_____

Pharmacy Address _____ Fax_____

Primary Insurance_____ **Policy id**_____

Secondary Insurance_____ **Policy id**_____

Assignment of Benefits:

I authorize the release of nay medical information necessary to process my claim(s). I permit a copy of this authorization to be used in place of the original. This authorization may be revoked at any time in writing by either my insurance company or me.

SIGNATURE_____ DATE_____

I hereby authorize Digestive Disease Consultants to apply for benefits on my behalf for covered services rendered by the physician. I request that payment from my insurance company be made directly to Digestive Disease Consultants and applied to my account.

I certify that the information I have reported with regard to my insurance coverage is correct. I agree to make restitution on all charges/fees denied by the insurance company for reasonable cause.

Signature_____ Date_____

General Medical Information:

Patient Name_____ **Date of Birth**_____

Current Primary Care Physician_____

List of Current Medications_____

_____

_____

Allergies to Medication_____

Do you drink alcohol regularly Yes/No How many drinks per week_____

Do you smoke Yes/No How much _____

Past Medical History:

Surgical History _____

_____

Have you ever experienced any of the following: Circle all that apply

Hypertension Heart Attack Hepatitis Heart Valve Replacement Seizures Diabetes Kidney Disease
Cancer(Type)_____ Other_____

Recent Symptoms:

Circle symptoms you are currently having or have had recently:

Constipation Dark Urine Rectal Itching Diarrhea Indigestion Yellowish Skin Rectal Bleeding

Black Stool Abdominal Pain Vomiting Blood Nausea/Vomiting-how long_____

Weight Loss-how many pounds_____ Difficulty swallowing liquids Difficulty swallowing Solids

Other_____

Personal History:

Last Colonoscopy & Where_____

Last Flexible Sigmoidoscopy & Where_____

Last Upper Endoscopy & Where_____

Family History: State who (parents, grandparents, siblings etc)

Colon Cancer (age) _____

Other Cancer-What kind_____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

NAME_____ SOCIAL SECURITY NUMBER_____

ADDRESS_____TELEPHONE _____

PURPOSE OF CONSENT: BY SIGNING THIS FORM, YOU WILL CONSENT TO OUR USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT ACTIVITIES AND HEALTHCARE OPERATIONS.

NOTICE OF PRIVACY PRACTICES: YOU HAVE THE RIGHT TO READ OUR NOTICE OF PRIVACY PRACTICES BEFORE YOU DECIDE WHETHER TO SIGN THIS CONSENT. OUR NOTICE PROVIDES A DESCRIPTION OF OUR TREATMENT, PAYMENT ACTIVITIES AND HEALTHCARE OPERATION, OF THE USES AND DISCLOSURES WE MAY MAKE OF YOUR PROTECTED HEALTH INFORMATION, AND OF OTHER IMPORTANT MATTERS ABOUT YOUR PROTECTED HEALTH INFORMATION. A COPY OF OUR NOTICE ACCOMPANIES THIS CONSENT. WE ENCOURAGE YOU TO READ IT CAREFULLY AND COMPLETELY BEFORE SIGNING THIS CONSENT.

WE RESERVE THE RIGHT TO CHANGE OUR PRIVACY PRACTICES AS DESCRIBED IN OUR NOTICE OF PRIVACY PRACTICES. IF WE CHANGE OUR PRIVACY PRACTICES, WE WILL ISSUE A REVISED NOTICE OF PRIVACY PRACTICES, WHICH WILL CONTAIN THE CHANGES. THOSE CHANGES MAY APPLY TO ANY OF OUR PROTECTED HEALTH INFORMATION THAT WE MAINTAIN.

YOU MAY OBTAIN A COPY OF OUR NOTICE OF PRIVACY PRACTICES, INCLUDING ANY REVISIONS OF OUR NOTICE, AT ANY TIME BY CONTACTING:

CONTACT PERSON: OFFICE MANAGER
ADDRESS: 2151 Riverside Avenue, JACKSONVILLE FL 32204
TELEPHONE: 904-388-8686 FAX 904-388-4445

RIGHT TO REVOKE: YOU WILL HAVE THE RIGHT TO REVOKE THIS CONSENT AT ANY TIME BY GIVING US WRITTEN NOTICE OF YOUR REVOCATION SUBMITTED TO THE CONTACT PERSON LISTED ABOVE. PLEASE UNDERSTAND THAT REVOCATION, AND THAT WE MAY DECLINE TO TREAT YOU OR TO CONTINUE TREATING YOU IF YOU REVOKE THIS CONSENT.

SIGNATURE

I_____HAVE HAD FULL OPPORTUNITY TO READ AND CONSIDER THE CONTENTS OF THIS CONSENT FORM AND YOUR NOTICE OF PRIVACY PRACTICES. I UNDERSTAND THAT, BY SIGNING THE CONSENT FORM, I AM GIVING MY CONSENT TO YOUR USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT ACTIVITIES AND HEALTHCARE OPERATIONS.

SIGNATURE_____ **DATE**_____

Name(s) of person authorized to discuss or request medical and billing information:

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____