Digestive Health Associates of Northern Michigan, P.C.
4100 Park Forest Drive, Suite 208, Traverse City, MI 49684
Telephone: (231) 935-5710 Fax: (231) 935-9045 Web: https://www.dha-nm.com

PATIENT INFORMATION FORM

DATE / /					
LAST	FIRST	MIDDLE	NICKNAME		
PERMANENT ADDRESS	CITY	STATE	ZIP		
SECONDARY/MAILING ADDRESS	CITY	STATE	ZIP		
HOME PHONE ( )	WORK PHONE ( )	CELL PHONE ( )	E-MAIL ADDRESS		
SOCIAL SECURITY # – –	BIRTHDATE / /	GENDER ☐M ☐F	MARITAL STAUS S – M – W – D	EMPLOYER	
ETHNICITY ☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO	RACE ☐ AFRICAN AMERICAN ☐AMERICAN INDIAN OR ALASKA NATIVE ☐ASIAN ☐CAUCASIAN ☐NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐MULTIRACIAL ☐ OTHER		PREFERRED LANGUAGE ☐ ENGLISH ☐ OTHER _____		
SPOUSE	SPOUSE SOCIAL SECURITY # – –	SPOUSE BIRTHDATE / /	SPOUSE EMPLOYER		
GUARDIAN	GUARDIAN RELATIONSHIP	GUARDIAN BIRTHDATE / /	GUARDIAN PHONE		
EMERGENCY CONTACT	EMERGENCY CONTACT RELATIONSHIP	EMERGENCY CONTACT PHONE #			
REFERRING PHYSICIAN	PRIMARY CARE PHYSICIAN				

AUTHORIZATION TO RELEASE INFORMATION

I, _____ authorize Digestive Health Associates of Northern Michigan, P.C. (Drs. Carroll, Galan, Goldman, Hegewald, Henbest, Kathy Holmstrom-Baker, PA-C, Sarah Flickinger, PA-C, Rachael Carter, PA-C, Ana Zubaryeva, PA-C, Anne-Marie Deming, PA-C) to release and/or discuss information relevant to my care to the following individuals:

_____Spouse (Name) _____

_____Other (Name and Relationship) _____

I also authorize information about my health care, including appointments, test results or other messages, to be left on my answering machine, in the event that I am not available.

_____ Yes _____No

I request payment of authorized Medicare or other insurance benefits to be made to either myself or on my behalf to Digestive Health Associates of Northern Michigan for any services rendered to me. I authorize release of medical information about me to the Health Care Financing Administration (Medicare) and/or my insurance carrier. This information is to be used for the purpose of evaluating and administrating benefits.

_____Medicare
_____Other Insurance (Name of Company) _____

I understand that I am financially responsible for any amount not covered by my insurance contract. I accept responsibility for obtaining necessary referral forms.

This release will be considered valid from the date indicated below and will remain in effect until such time as I withdraw it in writing.

_____ _____ _____
Signature of Patient Date Witness

Digestive Health Associates of Northern Michigan, P.C.

Acknowledgement of Receipt
Notice of Privacy Practices

I understand Digestive Health Associates of Northern Michigan, P.C.'s notice of privacy practices are available upon request and are also posted on the bulletin board in the waiting room of their office.

_____ _____

Patient Signature Date

_____

Print Name

_____

Date of Birth

HEALTH HISTORY QUESTIONNAIRE

Name:_____
Age:_____ DOB:_____ ☐Male ☐Female
Today's Date:_____Reason for Visit:_____
Allergies:_____

PAST HISTORY (✓ all that apply)
☐ Seizure_____
☐ Stroke/TIA_____
☐ Head Injury(when)_____
☐ Congestive Heart Failure_____
☐ Heart Attack (when)_____
☐ High Blood Pressure_____
☐ Bleeding ☐ Clotting Problem
☐ High Cholesterol
☐ Asthma ☐ Emphysema
☐ Hiatal Hernia ☐ Ulcer
☐ Liver Disease ☐ Hepatitis
☐ Ostomies
☐ Kidney Disease ☐ Kidney Stone
☐ Diabetes ☐ Hypoglycemia
☐ Thyroid Problems
☐ Arthritis ☐ Limited Motion
☐ HIV ☐ AIDS
☐ Cancer/Tumor (site)_____
☐ Chemotherapy/ Radiation_____
☐ Depression ☐Alcoholism
☐ Suicide Attempt
☐ Chronic Pain

LIST GASTROINTESTINAL SURGERIES (approximate dates):
(Please use back for additional info)
_____
_____
_____
_____
_____
_____

OTHER SURGERIES:
_____
_____
_____
_____
_____

MEDICINE (Type and Dosage)
_____
_____
_____
_____
_____
_____

REVIEW OF SYSTEMS – (Recently)

Constitutional
☐ Chills ☐ Fever
☐ Uneasiness ☐ Weight loss

HEENT
☐ Double Vision ☐ Ear Infection
☐ Eye Pain ☐ Nasal Congestion
☐ Sinus Infection ☐ Sore Throat

Respiratory
☐ Shortness of Breath
☐ Frequent Cough ☐ Wheezing
☐ Severe Chest Pain

Cardiovascular
☐ Chest Pain ☐ Extreme Edema
☐ Palpitations

Gastrointestinal
☐ Abdominal Pain
☐ Change in bowel habits
☐ Constipation ☐ Diarrhea
☐ Heartburn ☐ Vomiting of Blood
☐ Blood in Stool ☐ Black Stool
☐ Loss of appetite
☐ Nausea ☐ Reflux ☐ Vomiting

Genitourinary
☐ Painful Urination
☐ Blood in Urine
☐ Urinary frequency
☐ Urinary Incontinence
☐ Urinary Retention

Reproductive
☐ Breast lumps ☐ Breast Pain
☐ Vaginal discharge
☐ Penile discharge
☐ Sexual dysfunction

Metabolic/Endocrine
☐ Cold intolerance
☐ Excessive thirst
☐ Heat intolerance
☐ Enlarged Breast in Men

Neurological
☐ Dizziness ☐ Headache
☐ Numbness ☐ Tremors
☐ Vertigo

Psychiatric
☐ Anxiety ☐ Depression
☐ Increased Stress

Integumentary
☐ Contact allergy ☐ Hives
☐ Scratching ☐ Rash

Musculosketal
☐ Back Pain ☐Muscle Pain
☐ Joint Pain

Hematologic/Lymphatic
☐ Easy bleeding
☐ Easy bruising
☐ Swollen Lymph Nodes

Immunologic
☐ Asthma
☐ Chemicals in work place
☐ Food allergies
☐ Immunosuppression
☐ Seasonal allergies

Other Medical Problems
_____
_____
_____
_____
_____

FAMILY HISTORY
(List Family Member and Type)
☐ Heart Disease _____
☐ Cancer _____
☐ Colon Polyps_____
☐ Colon Cancer_____
☐ Diabetes _____
☐ Other _____

SOCIAL HISTORY
Occupation _____
☐ Smoke Cigarettes
Packs per day_____
For How Long_____
Year Quit_____
☐ Drinks caffeine
Cups per day_____
☐ Recreational drugs
☐ Consumes alcohol
Frequency_____
For how long_____
Year quit_____

REVIEWED BY_____DATE_____

Digestive Health Associates of Northern Michigan, P.C.

"No Show" Policy
For Office Visits & Procedures

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide adequate notice. This will enable another person who is waiting for an appointment to be scheduled in that appointment slot. With cancelations made less than 24-48 hours notice, we are unable to offer that appointment slot to other people.

- Patients who fail to show for their scheduled office appointment or do not notify the office within 24 hours of their scheduled appointment time, shall be subject to a "No Show" penalty of $50.00. In the event of an actual emergency and prior notice could not be given, consideration will be given - and an exception may be granted.
- Patients who fail to show for their scheduled procedure appointment or do not notify the office 2 business days before their scheduled appointment time shall be subject to a "No Show" penalty of $150.

We understand that special unavoidable circumstances may cause you to cancel within this time frame. Fees in this instance may be waived but only with management approval.

Please sign that you have read, understand, and agree to this "No Show" Policy.

_____ _____

Patient Signature Date

_____

Print Name

_____

Date of Birth