Digestive Institute of Arizona
3011 S. Lindsay Rd. #115 Gilbert, AZ 85295
3030 N. Central Ave. #803 Phoenix, AZ 85012
602·541·1575 ~ Fax: 602·926·1418
Front desk@diarizona.co

Patient Registration Information

Patient's Personal Information

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Sex:** ☐ Male ☐ Female

Race: ☐ White ☐ Black ☐ Asian ☐ Native American ☐ Mexican-American ☐ Alaskan Native ☐ Pacific Islander
Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Decline to answer

Name: _____ (last name) _____ (first name) _____ (initial)

Date of Birth: ____ / ____ / ____ Social Security #: ____ - ____ - ____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Address: _____ Apt. #: _____ City: _____ State: ____ Zip: _____

Patient's / Responsible Party Information

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Name: _____ (last name) _____ (first name) _____ (initial)

Date of Birth: ____ / ____ / ____ Social Security #: ____ - ____ - ____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Address: _____ Apt. #: _____ City: _____ State: ____ Zip: _____

Patient's Insurance Information

Please present insurance cards to receptionist.

PRIMARY Insurance Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Name of Insured: _____ Date of Birth: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy #: _____ Group #: _____ Copay: $_____

SECONDARY Insurance Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Name of Insured: _____ Date of Birth: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy #: _____ Group #: _____ Copay: $_____

Patient's Referral Information / Primary Care Physician

Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: (____) _____ Fax: (____) _____

Pharmacy Information

Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: (____) _____ Fax: (____) _____

Emergency Contact

Is this person legally allowed to make medical decisions on your behalf? ☐ Yes ☐ No

Name: _____ Relationship: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Assignment of Benefits • Financial Agreement

I hearby give authorization for payment of insurance benefits to be made directly to Digestive Institute of Arizona, forservices rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of defaultI agree to pay all costs of collections and reasonable attorney's fees. I hearby authorize this healthcare provider to reaease all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original and understand that Digestive Institute of Arizona utilizes dictation services or AI powered scribing. I have been notified and authorize.

Date: _____ Your Signature: _____

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MEDICAL HISTORY & REVIEW OF SYSTEMS

Patient Name: _____ Date of Birth: _____ Date: _____

1. MEDICAL HISTORY BY BODY SYSTEM

Check any conditions you have now or have had in the past. Add details for checked items as needed.

GASTROINTESTINAL

☐ Acid reflux / GERD ☐ Hiatal hernia ☐ Difficulty swallowing / stricture
☐ Gastritis / stomach ulcer ☐ H. pylori ☐ Celiac disease
☐ Crohn's disease / ulcerative colitis ☐ IBS ☐ Colon polyps
☐ Diverticulosis / diverticulitis ☐ Liver disease / hepatitis ☐ Fatty liver / cirrhosis
☐ Gallstones / gallbladder disease ☐ Pancreatitis ☐ Other GI condition _____

CARDIAC

☐ Heart disease / coronary artery disease ☐ Heart attack ☐ Heart failure
☐ Arrhythmia / atrial fibrillation ☐ Heart valve disease ☐ High blood pressure
☐ High cholesterol ☐ Other cardiac condition _____

PULMONARY

☐ Asthma ☐ COPD / emphysema ☐ Sleep apnea
☐ Chronic lung disease ☐ Other pulmonary condition _____

DERMATOLOGY

☐ Eczema / psoriasis ☐ Skin cancer ☐ Chronic rash / skin condition
☐ Other dermatologic condition_____

GENITOURINARY

☐ Kidney disease ☐ Kidney stones ☐ Recurrent urinary tract infections
☐ Bladder condition ☐ Other genitourinary condition_____

HEMATOLOGY / ONCOLOGY

☐ Anemia ☐ Bleeding disorder ☐ Blood clots / DVT / PE
☐ Abnormal bleeding ☐ Cancer (specify type) ☐ Other blood disorder / cancer _____

ENDOCRINOLOGY

☐ Diabetes (Type 1 / Type 2) ☐ Thyroid disease ☐ Adrenal / pituitary disorder
☐ Osteoporosis ☐ Other endocrine condition_____

RHEUMATOLOGY

☐ Rheumatoid arthritis ☐ Lupus ☐ Other autoimmune disease
☐ Gout ☐ Other rheumatologic condition _____

NEUROLOGIC / OTHER

☐ Stroke / TIA ☐ Seizures ☐ Neuropathy
☐ Chronic neurologic condition ☐ Other chronic condition_____

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Additional details (condition, approximate year diagnosed, treatment):

2. FAMILY HISTORY — GASTROINTESTINAL CONDITIONS / CANCERS

☐ No known family history of GI conditions/cancers

Has any close relative had any of the following? Check all that apply.

☐ Colon cancer ☐ Colon polyps ☐ Ulcerative colitis ☐ Crohn's disease

☐ Pancreatic cancer ☐ Stomach cancer ☐ Esophageal cancer

☐ Liver cancer ☐ Bile duct / gallbladder cancer ☐ Other GI cancer

Relative(s), condition, and age at diagnosis (if known):

3. SURGERIES AND GI PROCEDURES

Prior surgeries (procedure and approximate year):

Prior upper endoscopy / EGD (date and findings, if known):

Prior colonoscopy (date and findings, if known):

4. ALLERGIES

☐ No known allergies (NKA) ☐ Medication allergies

☐ Food allergies ☐ Latex / adhesive / other

List allergy and reaction (include severity if known):

5. CURRENT MEDICATIONS

Include prescriptions, over-the-counter medicines, vitamins and supplements.

Medication / dose:

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REVIEW OF SYSTEMS

Check any symptoms you are currently experiencing. Leave unchecked if not present.

GENERAL: ☐ Fever ☐ Unintentional weight loss ☐ Fatigue

GASTROINTESTINAL: ☐ Abdominal pain ☐ Heartburn / reflux ☐ Difficulty swallowing ☐ Nausea / vomiting ☐ Bloating ☐ Constipation ☐ Diarrhea ☐ Blood in stool / black stool ☐ Change in bowel habits ☐ Jaundice

CARDIOPULMONARY: ☐ Chest pain ☐ Shortness of breath ☐ Persistent cough

GENITOURINARY: ☐ Painful urination ☐ Blood in urine

NEUROLOGIC: ☐ Dizziness ☐ Weakness ☐ Severe / new headache

SKIN / MUSCULOSKELETAL: ☐ Rash ☐ Joint pain ☐ Itching

Other symptoms or information you would like your provider to be aware of?

_____

_____

_____

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AUTHORIZATIONS AND CONSENT

ASSIGNMENT AND RELEASE: I hereby assign my insurance or other third party carrier benefits to be paid directly to the Physician Practice, realizing I am responsible for any resulting balance. I also authorize the Physician to release any information required to process this claim to my insurance carrier and/or to my employer or prospective employer (for employer sponsored/paid for claims). I acknowledge that I am financially responsible for services rendered, and failure to pay any outstanding balances may result in collection procedures being taken. Further, I agree that if this account results in a credit balance, the credit amount will be applied to any outstanding accounts of mine, or to a family member whose account I am guarantor for.

ELECTRONIC CHECK CONVERSION: When you provide a check as payment, you authorize us either to use information from your check to make a one- time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account the same day.

CONSENT FOR TREATMENT: I hereby authorize the physicians, midlevel providers, nurses, medical assistants, and other Practice staff to conduct such examinations, and to administer treatment and medications as they deem necessary and advisable.

NO SHOW POLICY: I understand if I fail to come for a scheduled appointment or cancel at least 24 hours prior to the appointment, I will be considered a "no show" and may be subject to a "no show" charge per occurrence. Ongoing occurrences of no shows may result in dismissal from the Practice.

I understand the Financial and No Show Policies, Authorizations and Consent for Treatment, and hereby agree to them:

Patient or Parent/Guardian if Minor Date of Birth Date

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A federal law was passed in 2014 and became effective on September 30, 2014, governing how we may contact you via telephone, text, and email. Listed below are some of the reasons we may need to contact you via telephone, text, or email:

- Appointment reminders
- Follow up with test results
- Reminder calls about annual preventive care due
- Email or fax with patient forms to complete prior to your appointment
- Notification of medication renewals
- Notification of surgery time and date
- Notification of prepayments for surgeries and procedures
- Follow up calls after surgeries or procedures

Consent to Contact

By providing a telephone number, I expressly consent and authorize the physician practice, any practitioner or clinical provider as well as any of their related entities, agents, or contractors, including but not limited to schedulers, marketers, advertisers, debt collectors, and other contracted staff (collectively referred to herein as "Provider") to contact me through the use of any dialing equipment (including a dialer, automatic telephone dialing system, and/or interactive voice recognition system) and/or artificial or prerecorded voice or message. I expressly agree that such automated calls may be made to any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by, or associated with me and obtained through any source including, but not limited to, any number I am providing today, have provided previously or may provide in the future in connection with the medical goods and services and/or my account. By providing this express consent, I specifically waive any claim I may have for the making of such calls, including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing a telephone number, I expressly consent to the receipt of text messages from Provider at any telephone number (including numbers assigned to any cellular or other service for which I may be charged for the call) used by, or associated with, me and obtained through any source including, but not limited to, any number I have provided previously or may provide in the future in connection with my account. By providing this express consent, I specifically waive any claim I may have for the making of such calls, including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C. § 227. By providing a telephone number, I represent I am the subscriber or owner or have the authority to use and provide consent to call the number.

By providing my email address now or at any time in the future in connection with the medical goods and services provided and/or my account, I expressly opt-in to the receipt of email communications from Provider for or related to the medical goods or services provided, my account, and other services such as financial, clinical and educational information including exchange news, changes to health care law, health care coverage, care follow up, and other healthcare opportunities, goods and services. By providing this express consent, I specifically waive any claim I may have for the sending of such emails, including any claim under federal or state law and specifically any claim under the CAN-SPAM Act, 15 U.S.C.§ 7701, et seq. By providing an email address, I represent I am the subscriber or owner or have the authority to use and provide consent to contact the email address.

I understand that providing a phone number and/or email address is not a condition of receiving medical services. I also understand that I may revoke my consent to contact at any time by directly contacting Provider or utilizing the opt-out method that will be identified in the applicable communication.

I have read and understand the above and consent to contact as described:

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Email: _____

***Minors or Users Requiring Caregivers - Acknowledgement of Consent to Contact:**

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Email: _____

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PHI DISCLOSURE TO FAMILY MEMBERS

You may authorize us to contact a family member regarding your medical care of financial matters. This is to acknowledge that you authorize Digestive Institute of Arizona to disclose you PHI to the following individuals (Check all that apply):

Name _____ Relationship to Patient _____

Telephone _____ Email _____

Date _____

Types of information: ☐ Appointment Reminders ☐ results (Lab test, x-Ray, etc.) ☐ Financial ☐ Other

Okay to contact via: ☐ Telephone ☐ Leave a Voice Mail ☐ Email ☐ Text ☐ Other

NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGMENT

A Notice of Privacy Practices (NPP) is provided to all patients. This Notice of Privacy Practices identifies 1. How medical information about you may be used or disclosed. 2. Your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information and request additional restrictions on our uses and disclosures of that information. 3. Your rights to complain if you believe your privacy rights have been violated. 4. Our responsibilities for maintaining the privacy of your medical information.

The undersigned certifies that he/she has read the foregoing and may review/receive a copy of the Notice of Privacy Practices and is the patient or the patients representative.

Name of Patient _____ Signature _____

Name of Representative _____ Signature of Representative _____

Date _____