Gastroenterology Specialists

Diplomate, American Board Internal Medicine and Gastroenterology

Steven A. Meckstroth, M.D.
Manuel F. Bustamante, M.D.
William Gonzalez, PA-C
Karina Hooper, PA-C

Patient Interview Form

Patient Information

First Name: ____________________ Last Name: ____________________

MRN: ____________________ Date of Birth: ____________________

Age: ____________________ Notes: ____________________

Race

- ◯ White/Caucasian
- ◯ Black or African American
- ◯ Asian
- ◯ Hispanic or Latino
- ◯ American Indian or Alaska Native
- ◯ Native Hawaiian Or Other Pacific Islander
- ◯ Mixed
- ◯ Other
- ◯ Unknown
- ◯ Patient declines to provide information

Ethnicity

- ◯ Hispanic or Latino
- ◯ Not Hispanic or Latino
- ◯ Patient declines to provide Information

Gender

- ◯ Male
- ◯ Female
- ◯ Other

Preferred Language

- ◯ English
- ◯ Spanish
- ◯ Other: ____________________

Contact Preference

- ◯ Letter
- ◯ Mobile Phone
- ◯ Home Phone
- ◯ Other: ____________________

Allergies

- ◯ Patient has no known allergies
- ◯ Patient has no known drug allergies
- ◯ Codeine Sulfate
- ◯ Penicillins
- ◯ Sulfa (Sulfonamide Antibiotics)
- ◯ Other __________
- ◯ Anesthesia

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Current Medications

- ⬭ None

Name	Dose	How taken?

Immunizations

- ⬭ None
- ⬭ Hep A, adult
- ⬭ Hep B, adult

Diagnostics Studies/Tests

- ⬭ None

Past or Present Medical Conditions

- ⬭ None

⬭ Anemia	⬭ Cirrhosis	⬭ Colitis	⬭ Colon cancer	⬭ Colon polyps
⬭ Crohn's Disease	⬭ Pancreatitis	⬭ Diabetes Mellitus	⬭ Diverticulitis	⬭ Diverticulosis
⬭ Duodenal Ulcer	⬭ Fatty Liver	⬭ Gallstones	⬭ Hepatitis	⬭ Hepatitis B
⬭ Hepatitis C	⬭ Hiatal hernia	⬭ IBS	⬭ Lactose Intolerance	⬭ Kidney Stones
⬭ Glaucoma	⬭ Stomach Ulcer	⬭ Ulcerative Colitis	⬭ Asthma	⬭ Atrial Fibrillation
⬭ Back Pain (chronic)	⬭ Breast cancer	⬭ Skin cancer	⬭ Chronic Lung Disease	⬭ Congestive Heart Failure
⬭ Depression	⬭ Emphysema	⬭ Stroke	⬭ Lupus	⬭ Gout
⬭ Heart Attack	⬭ Heart Murmurs	⬭ High Blood pressure	⬭ High Cholesterol	⬭ High Triglycerides
⬭ History of Suicide Attempt	⬭ Irregular Heart Beat	⬭ Chronic Kidney Disease	⬭ Kidney Failure	⬭ TB exposure
⬭ Migraines	⬭ Osteoarthritis	⬭ Paralysis	⬭ Parkinsons	⬭ Pneumonia
⬭ Rheumatic Fever	⬭ Rheumatoid arthritis	⬭ Seizures	⬭ Uterine cancer	⬭ Sleep apnea
⬭ Thyroid disorder	⬭ Other ______________________			

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Previous Procedures

- ⬭ None

⬭ Colonoscopy	⬭ EGD	⬭ Adenoidectomy	⬭ C-Section	⬭ Cardiac Surgery
⬭ Gallbladder removed	⬭ Hysterectomy	⬭ Joint Surgery	⬭ Prostatectomy	⬭ Thyroidectomy
⬭ Tonsillectomy	⬭ Pacemaker	⬭ Nephrectomy	⬭ Gastric By-pass	⬭ Gastric Band
⬭ Breast Augmentation	⬭ Liver Biopsy	⬭ Hemorrhoidectomy	⬭ Coronary artery bypass surgery	

Social History

Occupation: ______________________ Number of Children: ______________

Marital Status

⬭ Single ⬭ Married ⬭ Divorced ⬭ Separated ⬭ Widowed

Alcohol

⬭ None

Type	Quantity	Number	Frequency

Tobacco

Smoking Status	⬭ Current every day smoker	⬭ Current some day smoker	⬭ Former smoker	⬭ Never smoker
	⬭ Smoker, current status unknown	⬭ Unknown if ever smoked		

Drug Use

⬭ None

Type	Quantity	Number	Frequency
⬭ Narcotics			
⬭ Other			

Exercise

⬭ None

⬭ I walk	⬭ I jog	⬭ I Bike	⬭ I Golf	⬭ Tennis
⬭ Lift Weights	⬭ I swim	⬭ I do aerobics		

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Family Medical History

◯ No knowledge of family history

No family history of ◯ Colon cancer ◯ Polyps

Diagnoses	Mother	Father	Sister	Brother	Daughter	Son	Grandmother	Grandfather	Other	Unknown
Colon Cancer	O	O	O	O	O	O	O	O	O	O
Colon Polyps	O	O	O	O	O	O	O	O	O	O
Ulcerative colitis, unspecified	O	O	O	O	O	O	O	O	O	O
Crohn's Disease	O	O	O	O	O	O	O	O	O	O
Diabetes	O	O	O	O	O	O	O	O	O	O
Cancer, specify_____________________	O	O	O	O	O	O	O	O	O	O
Esophageal Cancer	O	O	O	O	O	O	O	O	O	O
Impaired gallbladder function	O	O	O	O	O	O	O	O	O	O
Heart Trouble	O	O	O	O	O	O	O	O	O	O
Liver Cancer	O	O	O	O	O	O	O	O	O	O
Liver Disease	O	O	O	O	O	O	O	O	O	O
Pancreas Disease/Cancer	O	O	O	O	O	O	O	O	O	O
Stomach Cancer	O	O	O	O	O	O	O	O	O	O
Ulcer Disease	O	O	O	O	O	O	O	O	O	O
Irritable bowel syndrome	O	O	O	O	O	O	O	O	O	O

Review of Systems

Allergic/Immunologic

◯ None	Yes	No
HIV Exposure	O	O
persistent infections	O	O
strong allergic reactions or urticarial	O	O

Cardiovascular

◯ None	Yes	No
chest pain	O	O
dyspnea with exercise	O	O
irregular heart beat	O	O
orthopnea	O	O
palpitations	O	O
peripheral edema	O	O
syncope	O	O

Gastrointestinal

◯ None	Yes	No
abdominal swelling	O	O
change in bowel habits	O	O
constipation	O	O
diarrhea	O	O
gas	O	O
heartburn	O	O
jaundice	O	O
nausea	O	O
rectal bleeding	O	O
stomach cramps	O	O
vomiting	O	O
difficulty swallowing	O	O
dyspepsia	O	O
abdominal pain upper	O	O

Integumentary

◯ None	Yes	No
allergies	O	O
dryness	O	O
hives	O	O
itching	O	O
jaundice	O	O
lesions	O	O
rashes	O	O

Musculoskeletal

◯ None	Yes	No
arthritis	O	O
back pain	O	O
gout	O	O
joint deformity	O	O

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Constitutional

◯ None	Yes	No
fatigue	O	O
fever	O	O
loss of appetite	O	O
malaise	O	O
sweats	O	O
weight gain	O	O
weight loss	O	O

ENMT

◯ None	Yes	No
difficulty swallowing	O	O
dizziness	O	O
ear pain	O	O
nasal obstruction	O	O
nose bleeds	O	O
sore throat	O	O
hearing loss	O	O

Endocrine

◯ None	Yes	No
excessive thirst	O	O
hair loss	O	O
heat intolerance	O	O

Eyes

◯ None	Yes	No
double vision	O	O
loss of vision	O	O
photophobia	O	O

abdominal pain lower	O	O
anal/rectal pain	O	O
belching	O	O
black stools	O	O
bloating	O	O
dairy intolerance	O	O
hemorrhoids	O	O
mucus in stool	O	O
pain with bowel movement	O	O
rectal urgency	O	O
reflux	O	O
soiling stool/incontinence	O	O
weight loss less than 10lbs	O	O
weight loss more than 10lbs	O	O
weight gain less than 10lbs	O	O
weight gain more than 10lbs	O	O

Genitourinary

◯ None	Yes	No
dark urine	O	O
decrease in urine flow	O	O
dysuria	O	O
frequent urinary infections	O	O
frequent urination	O	O
hematuria	O	O
impotence	O	O
nocturia	O	O
urethral discharge or incontinence	O	O

Hematologic/Lymphatic

◯ None	Yes	No
bleeding gums or palpable lymph nodes	O	O
easy bruising	O	O
prolonged bleeding	O	O

joint pain	O	O
muscle weakness	O	O
stiffness	O	O

Neurological

◯ None	Yes	No
dizziness	O	O
fainting	O	O
frequent headaches	O	O
migraine	O	O
numbness or tingling	O	O
seizures	O	O
tremors	O	O
vertigo	O	O
memory loss	O	O

Psychiatric

◯ None	Yes	No
anxiety	O	O
depression	O	O
difficulty sleeping	O	O
hallucinations	O	O
nervousness	O	O
panic attacks	O	O
paranoia	O	O

Reparatory

◯ None	Yes	No
asthma	O	O
dyspnea	O	O
excessive sputum	O	O
coughing up blood	O	O
shortness of breath w/exercise	O	O
wheezing	O	O

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PHARMACY ______________________________

Name: ______________________________

Name: ______________________________
Last First Middle Initial

Current Address: ______________________________

____

Northern Address: ______________________________

Social Security#: ______________ Marital Status: ☐ M ☐S ☐ W ☐ D, Sex: ☐M ☐ F

Date of Birth: ______________________________

Home Phone: ______________ Cell Phone: ______________

Northern Phone: ______________ Work Phone: ______________

Employer: ______________ Occupation: ______________

In case of emergency please list a name, relationship and phone number **OTHER** than the above numbers

____

Referring Doctor: ______________ Phone: ______________

Primary Care Doctor: ______________ Phone: ______________

E-mail: ______________________________

Primary Insurance Company Name: ______________________________

Subscriber: ______________ Subscriber Date of Birth: ______________

Secondary Insurance Company Name: ______________________________

Subscriber: ______________ Subscriber's Date of Birth: ______________

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INSURANCE:

In an area of different insurances policies, our office staff cannot possibly know the terms of your individual policy. Please review your plan booklet or check with your insurance representative if you are unsure weather services at Gastroenterology Specialists of Southwest Florida, P.A. are covered under your policy. It is your responsibility to know if the procedure you are having needs to be pre-certified. If this has not been done, make sure you contact your insurance company. ___________
(Initials)

If your insurance plan is terminated after we have checked eligibility or if your employer terminates your coverage retroactively, **YOU WILL BE RESPONSIBLE FOR THE BALANCE.** ___________
(Initials)

PAYMENT:

Unless other payments are approved by us in writing, your balance is due and payable when your statement is issued and past due if not received within 30(thirty) days of the issue date on the statement. Your responsibility will be the amount indicated on your stamen under “pay this amount”. We reserve the right to add any fees incurred by us for additional billing and collection services. For your convenience, we accept most VISA, MasterCard, Discover, bank debit cards and personal checks. There is a $15.00(fifteen) fee for any check returned by your bank. If necessary, we can set up a regular payment schedule for you. This form acknowledges that you have given us permission to report your account status to any credit agency such as a credit bureau if the agreed upon amount is not paid each month. You understand that if your account is submitted to an attorney or collection agency, or results in litigation, or if your past due amount is reported to a credit reporting agency, the fact that you have received treatment services at our office may become a matter of public record. Nonpayment of overdue balances may jeopardize continued care with Gastroenterology Specialists of Southwest Florida, P.A.

APPOINTMENTS:

If you are unable to keep your appointment, kindly give a 24 hour notice. Otherwise, a charge of $60.00(sixty) will apply. Your insurance will not cover this fee and you will be responsible for it. _______
(Initials)

RECORDS:

All requests for medical records must be requested in writing with a medical record release form.

You acknowledge and agree to all of the terms and conditions contained herein and this agreement will become effective on the date indicated below.

Patient’s name: ____

Responsible party: ____

Signature of patient or responsible party: ______________________________ Date: _______________

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Diplomate, American Board of Internal Medicine

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William González, PA-C
Karina Hooper, PA-c

PATIENT CONSENT FORM HIPAA COMPLIANT

With my consent, Gastroenterology Specialists of Southwest Florida, P.A. ("The Practice"), may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

I have the right to review the notice of privacy practices prior to signing this consent. The practice reserves the right to revise its notice of privacy practices at any time. A revised notice of privacy practices may be obtained by forwarding a written request to the practice at the address listed on this form.

With my consent, the practice may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results, among others. With my consent, the practice may mail or email to my home, or other designated location, any items that assist the practice in carrying out TPO, such as appointment reminders, patient's statements and others.

I have the right to request that the practice restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to the practice's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, the practice may decline to provide treatment to me.

I wish to allow the following person(s) access to my medical record.

______________________________ ______________________________
Name Relationship

______________________________ ______________________________
Name Relationship

Signature: ________________________ Date: ________________________

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MEDICAL RECORD RELEASE TO OTHER ENTITY

I, __________________________ hereby authorize Gastroenterology Specialists of Southwest Florida, P.A. to disclose the following protected health information to:

Dr's Name____________________________ Phone____________________

Address______________________________ Fax______________________

City, ST, ZIP___________________________

Medical Information to be released:

__________office visits (please specify dates) _________ test results (specify)

This authorization shall be in effect until ___________________ but no longer than one year from the date signed at which time this authorization to use or disclose protected information expires.

I understand that I have the right to revoke this authorization at any time by sending written notification to the Privacy Officer at 1656 Medical Blvd, Ste. 301, Naples, FL, 34110. I understand that a revocation is not effective to the extent that Gastroenterology Specialists of Southwest Florida, P.A. has relied on this authorization for the disclosure of the protected health information.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state laws.

Gastroenterology Specialists of Southwest Florida, P.A. will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to refuse to sign this authorization

_________________________________ ___________________

Signature of Patient or Representative Date

If Representative, relationship______________________________

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MEDICAL RECORD RELEASE FROM OTHER ENTITY

Authorization of disclosure of protected health information by another covered entity for use by Gastroenterology Specialists of Southwest Florida, P.A. from

Dr's Name_____________________________ Phone_____________________

Address_______________________________ Fax_______________________

City, ST, ZIP____________________________

Medical Information to be released:

__________office visits (please specify dates) _________ test results (specify)

This authorization shall be in effect until ___________________ but no longer than one year from the date signed at which time this authorization to use or disclose protected information expires.

I understand that I have the right to revoke this authorization at any time by sending written notification to the Privacy Officer at 1656 Medical Blvd, Ste. 301, Naples, FL, 34110

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state laws.

I understand that I have the right to refuse to sign this authorization

_____________________________________ ____________________

Signature of Patient or Representative Date

If Representative, relationship______________________________

_____________________________________ _____________________

Printed name Date of Birth