

REGISTRATION/HISTORY FORM
Brunswick Gastroenterology Associates
121 Medical Center Drive, Suite 3400, Brunswick
Phone: 207-725-1355

Appointment Date/Time: _____

Name:

Last: _____ First: _____ M.I.: _____

Address:

Mailing: _____ City: _____ State: _____ Zip: _____

Other Information:

Date of Birth: _____ Marital Status: M ___ D ___ Single ___ Separated ___ W ___

Soc. Sec. # (optional): _____ Occupation: _____ Employer: _____

Home Phone: _____ May we leave a message on an ans. machine? Y ___ N ___ None ___

Work Phone: _____ May we call you at work? Y ___ N ___ Cell Phone: _____

Emergency Contact:

Name: _____ Relation: _____ Phone: _____

Insurance:

If you have insurance, please hand us your card so that we may copy it for billing accuracy.

Primary Care Doctor: _____

EMPLOYER OF INSURED: (REQUIRED) _____

Referrals:

If your insurance company requires that you have a referral from your primary care physician prior to seeing a specialist, it is your responsibility to assure that the appropriate referral is made prior to receiving services from a physician at Brunswick Gastroenterology Associates. Without a referral we cannot bill your insurance company and you will be held responsible for payment.

Initials: _____ (Please initial so that we know that you have read this.)

CO-PAYMENT IS EXPECTED AT TIME SERVICES ARE RENDERED

Authorizations:

I hereby authorize payment of Medicare benefits or other insurance carrier's benefits to be made directly to Brunswick Gastroenterology Associates on my behalf. Furthermore, I authorize Brunswick Gastroenterology Associates to release any information requested from my insurance carrier to secure payment or to determine if benefits are payable. I understand that I am responsible for all charges not covered by this assignment. **This assignment will remain in effect until revoked by me in writing.**

Initials: _____ (Please initial so that we know that you have read this.)

If you have lab tests, x-rays, endoscopy or any other tests in which there are reports pending, it is the policy of this office to have you call the office to get the results (7) days after the test is done or as directed by the physician. We do not want you to assume the results are normal if you do not hear from this office.

Signature: _____ **Date:** _____

PATIENT HISTORY

Name: _____ DOB: _____ Primary Care Doctor: _____

1. **What is your chief complaint** (reason for your visit): _____

2. Do **you** have a **personal history** of any of the following? (Check **each** one)

YES	NO		YES	NO	
		Cardio/Pulmonary			Musculoskeletal/ Neuro/ Psych/Derm
<input type="checkbox"/>	<input type="checkbox"/>	Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/ Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Other psychological problems
<input type="checkbox"/>	<input type="checkbox"/>	Other Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disorders
<input type="checkbox"/>	<input type="checkbox"/>	Asthma			Gastrointestinal
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Hiatus hernia
		Endocrine/ GU	<input type="checkbox"/>	<input type="checkbox"/>	Stomach ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Gallstones
<input type="checkbox"/>	<input type="checkbox"/>	Pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>	Cirrhosis
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice (yellow skin)
<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
		Hematological	<input type="checkbox"/>	<input type="checkbox"/>	Other liver disease
<input type="checkbox"/>	<input type="checkbox"/>	Anemia (low blood)	<input type="checkbox"/>	<input type="checkbox"/>	Colon polyps
<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusions	<input type="checkbox"/>	<input type="checkbox"/>	Ulcerative colitis
		Other	<input type="checkbox"/>	<input type="checkbox"/>	Crohn's disease
<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Diverticulitis
<input type="checkbox"/>	<input type="checkbox"/>	Radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids
<input type="checkbox"/>	<input type="checkbox"/>	Cancer			

3. Are **you currently** having difficulty with any of the following?

YES	NO		YES	NO	
		General			Musculoskeletal/Neuro/Psych/Derm
<input type="checkbox"/>	<input type="checkbox"/>	Weight loss _____ lbs.	<input type="checkbox"/>	<input type="checkbox"/>	Sores/ rashes/ changes in moles
<input type="checkbox"/>	<input type="checkbox"/>	Loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Fever, chills or sweats	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
		EENT	<input type="checkbox"/>	<input type="checkbox"/>	Muscle weakness
<input type="checkbox"/>	<input type="checkbox"/>	Changes in vision	<input type="checkbox"/>	<input type="checkbox"/>	Problems with coordination
<input type="checkbox"/>	<input type="checkbox"/>	Inflammation in eyes	<input type="checkbox"/>	<input type="checkbox"/>	Numbness or tingling
<input type="checkbox"/>	<input type="checkbox"/>	Ringling/ buzzing in ears	<input type="checkbox"/>	<input type="checkbox"/>	Memory loss
<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Are you depressed?
<input type="checkbox"/>	<input type="checkbox"/>	Sinus problems			Gastrointestinal
		Cardio/Pulmonary	<input type="checkbox"/>	<input type="checkbox"/>	Regurgitation
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn
<input type="checkbox"/>	<input type="checkbox"/>	Swelling in legs	<input type="checkbox"/>	<input type="checkbox"/>	Nausea/vomiting
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty swallowing/food sticking
<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough/ wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal pain/belly pain
		Endocrine/GU	<input type="checkbox"/>	<input type="checkbox"/>	Bloating
<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to heat/ cold	<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	Blood/ pain/ burning on urination	<input type="checkbox"/>	<input type="checkbox"/>	Change in bowel habits
<input type="checkbox"/>	<input type="checkbox"/>	Women – problems with periods	<input type="checkbox"/>	<input type="checkbox"/>	Mucus in stools
		Hematological	<input type="checkbox"/>	<input type="checkbox"/>	Black stools
<input type="checkbox"/>	<input type="checkbox"/>	Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>	Blood in stools

Physician's Signature: _____ Date: _____

Name _____ DOB: _____

ALLERGIES

Are you allergic to iodine dyes? Y___ N___ Are you allergic to latex? Y___ N___

List all allergies to medications: If **NONE**, please check _____

OTHER

Do you use alternative treatments? Y___ N___

Do you smoke? Y___ N___ If yes, how much? _____ For how many years? _____

If you stopped, when? _____ If you stopped, how many years did you smoke? _____

Do you use alcohol? Y___ N___ If yes what type? _____ Amount? _____

If stopped, when? _____ If stopped, how many years did you use alcohol? _____

Have you ever used illicit (illegal) drugs? Y___ N___ If yes, what kind? _____

MEDICATIONS

List all medications & dosages (include herbal, vitamins and over-the-counter): If **NONE** please check _____

HOSPITALIZATIONS/ SURGERIES

Year	Hospital	Reason for hospitalization or surgery
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY HISTORY

Indicate any illnesses (for example, cancer, heart disease, diabetes, colon polyps, high blood pressure). Also, indicate if living or deceased and age.

Father: _____

Mother: _____

Brothers and sister: _____

Children: _____

OTHER MEDICAL PROBLEMS: _____

Physician's Signature: _____ Date: _____

PLEASE BRING THIS FORM WITH YOU TO YOUR APPOINTMENT