PATIENT REGISTRATION FORM (eCW)

PATIENT INFORMATION (Please print)

Patient's Legal Name: (Last)______________________________(First)____________________________________(MI) __________________

Preferred Full Name (if different from above): _______________________________

Address: ____

City, State, Zip:____

Home Phone Number (landline):____________________Cell:_______________________________Work: _______________________________

E-Mail Address:____Date of Birth: __________________________

Gender Identity: ☐ Female ☐ Male ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Genderqueer ☐ Choose not to disclose

☐ Additional Gender category not listed __________________________

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African American ☐ White
☐ Hispanic ☐ Chose not to disclose ☐ Other not listed __________________________

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Choose not to disclose

Preferred Language: ☐ English ☐ Spanish ☐ ASL ☐ Japanese ☐ Mandarin ☐ Korean ☐ French ☐ Indian: Hindi, Tamil, Gujarati etc
☐ Swahili ☐ Russian ☐ Arabic ☐ Vietnamese ☐ Haitian Creole ☐ Bosnian/Croatian/Serbian/Serbo-Croatian
☐ Albanian ☐ Burmese ☐ Tagalog ☐ Farsi-Iranian/Persian ☐ Portuguese ☐ Cambodian ☐ Other not listed_______

Patient Social Security Number:____-_______-_________

RESPONSIBLE PARTY INFORMATION (*If not self*) (Information used for patient balance statements)

Responsible party: ☐ Another patient ☐ Guarantor ☐ Self Check here if address and telephone information is same as patient ☐
Responsible party name: (Last)__________________________________(First)__________________________________(MI) ______________

Date of birth: MM_______/DD______/YYYY_______ Sex: ☐ Female ☐ Male
Responsible Party Social Security Number:_-_________-______Phone number: _________________
Address:________________________________City ________________________, State________ZIP: ______________

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in.

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last)____(First) _______________________________________

Phone number:____Do you have a living will? ☐ Yes ☐ No

Emergency contact relationship to patient:____ ☐ Guardian
Address____
____ City, State:_________________ZIP: _________________
Home phone:___________________________________Work hone:____________________Ext. ________

PRIMARY CARE PROVIDER

Primary Care Provider Name: (Last)____(First) _______________________________________
Phone number:____
Address____ City, State:_________________ZIP: _________________

PHARMACY

Pharmacy Name: ____Pharmacy Phone:_________________________________
Pharmacy Address:_______________________________ City, State:_________________ZIP: _________________

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GENERAL CONSENT FOR CARE AND TREATMENT CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or clinical nurse specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).
I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of patient or personal representative:________________________________Date: ________________________

Printed name of patient or personal representative:______________________________Relationship to patient:__________________

Last Updated: May 2018

Patient HIPAA Acknowledgment and Consent Form

Kansas City Gastroenterology and Hepatology, LLC			
Patient Last Name (Printed)	Patient First Name (Printed)	MI	Date of Birth (MM/DD/YYYY)

Notice of Privacy Practice/clinics

________ **(Patient/Representative initials)** I acknowledge that I have received the Notice of Privacy Practice, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practice.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM? I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Communications about My Healthcare

I agree the Provider or an agent of the Provider or an independent physician's office may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications

If at any time I provide an email address or cellphone number at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have provided or you or your EBO Servicer have obtained, at any text number forwarded, or transferred from that number. These instructions may include, but not be limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care.

Note: You may opt out of these communications at any time. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Note: This location uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated locations that share an electronic health record in which you have a relationship.

A photocopy of this consent shall be considered as valid as the original.

Patient HIPAA Acknowledgment and Consent Form

Kansas City Gastroenterology and Hepatology, LLC			
Patient Last Name (Printed)	Patient First Name (Printed)	MI	Date of Birth (MM/DD/YYYY)

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Release of Information.

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

I certify that I have read and fully understand the above statements from all pages and consent fully and voluntarily to its contents.

Patient/Representative Signature	Relationship to Patient (self, parent, legal guardian/representative, etc)	Date

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

- ***I do want*** ____ (Patient/Representative Initials) to designate the following individual to pick up a prescription order on my behalf:

NAME	Relationship to Patient

- ***I do not want*** ____ (Patient/ Representative Initials) to designate anyone to pick-up my prescription order.

Patients Name: ____ **DOB:** ____________________

Past Medical History

Have you ever had any operations? ____ No ____ Yes

If yes please list operation and year performed: ____

____

Have you had any serious medical illness(s) which were not a surgical operation? ____ No ____ Yes

If yes please list illness and year: ____

____

Have you ever had a serious injury? ____ No _____ Yes

If yes please list injury and year: ____

____

What medications or supplements are you taking? ___ None (okay to attach list)

Medication **Dosage** **Frequency**

____

____

____

____

____

____

Do you have any drug allergies? ____ No ____ Yes (If yes please list below along with reaction)

Allergy **Reaction**

____

____

Radiology

Have you had any of the following x-rays?

Chest	___No	___Yes	If yes, what date: ________________
Colon	___No	___Yes	If yes, what date: ________________
Stomach	___No	___Yes	If yes, what date: ________________
Kidney	___No	___Yes	If yes, what date: ________________
Gallbladder	___No	___Yes	If yes, what date: ________________

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Family History

Mother : Age_____

___ Alive
___ Deceased
___Colon cancer
___Ovarian cancer
___ Uterine cancer
___ Breast cancer
___ Heart attack
___ High blood pressure
___ Colon Polyps
___ Ulcers
___ Liver disease
___ Gall bladder disease
___ Diabetes
___ Ulcerative colitis or Crohns
___ Kidney disease
___ Other ____________________________

Father: Age _____

___Alive
___Deceased
___Colon Cancer
___Prostate Cancer
___Heart attack
___High blood pressure
___Colon Polyps
___Ulcers
___Liver Disease
___Gall bladder disease
___Diabetes
___Ulcerative colitis or Crohns
___Kidney disease
___Other: ________________________________

Children: Age(s)_____

___ Alive
___ Deceased
___Colon cancer
___Ovarian cancer
___ Uterine cancer
___ Breast cancer
___ Prostate cancer
___ Heart attack
___ High blood pressure
___ Colon Polyps
___ Ulcers
___ Liver disease
___ Gall bladder disease
___ Diabetes
___ Ulcerative colitis or Crohns
___ Kidney disease
___ Other ______________________________

Siblings: Age(s) ____

___Alive
___Deceased
___Colon cancer
___Ovarian cancer
___Uterine cancer
___Breast cancer
___Prostate cancer
___Heart attack
___High blood pressure
___Colon Polyps
___Ulcers
___Liver disease
___Gall bladder disease
___Diabetes
___Ulcerative colitis or Crohns
___Kidney Disease
___ Other : ________________________________

Social History

Marital status: ____ Single ____Married _____ Separated ____ Divorced ____ Widowed
Smoking status: ____ Never smoker ____Former smoker Year Quit _____ ____ Current smoker Packs per day ____
_____ Smokeless tobacco Alcohol: Do you drink alcohol ___ Yes ____ No If yes Drinks per week __________

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Patients Name: ____ **DOB:** ____________________

Review of systems, Please mark yes or no

Gastroenterology

Difficulty swallowing	__Yes __ No
Abdominal pain	__Yes __ No
Nausea	__Yes __ No
Vomiting	__Yes __ No
Constipation	__Yes __ No
Diarrhea	__Yes __ No
Blood in stool	__Yes __ No
Poor appetite	__Yes __ No
Heartburn	__Yes __ No
Bloating/belching	__Yes __ No

General

Chills	__Yes __ No
Weight loss	__Yes __ No
Fever/Night sweats	__Yes __ No
Fatigue/weakness	__Yes __ No
Loss of appetite	__Yes __ No

Dermatology

Rash	__Yes __ No
Bruises easily	__Yes __ No
Discoloration	__Yes __ No
Itching	__Yes __ No
Lumps	__Yes __ No

Endocrinology

Heat/cold intolerance	__Yes __ No
Hair loss	__Yes __ No
Excessive sweating	__Yes __ No

Neurology

Headache	__Yes __ No
Confusion	__Yes __ No

ENT/ Respiratory

Shortness of Breath	__Yes __ No
Mouth Sores	__Yes __ No
Nose Bleeds	__Yes __ No
Throat pain	__Yes __ No
Voice change	__Yes __ No
Chronic cough	__Yes __ No
Wheezing	__Yes __ No

Cardiology

Chest pain	__Yes __ No
Shortness of breath	__Yes __ No
Dizziness	__Yes __ No

Musculoskeletal

Joint pain	__Yes __ No
Joint swelling	__Yes __ No
Back pain	__Yes __ No
Muscle pain	__Yes __ No

Psychiatric

Memory loss	__Yes __ No
irritability	__Yes __ No
Depression	__Yes __ No
Anxiety	__Yes __ No
Tension/ Stress	__Yes __ No
Sleep disturbances	__Yes __ No

First Point of Contact Screening

Name: ____DOB: _______________Date: ______

We are committed to providing a safe environment for our patients and staff. Please complete the questions below and follow further instructions from the care team.

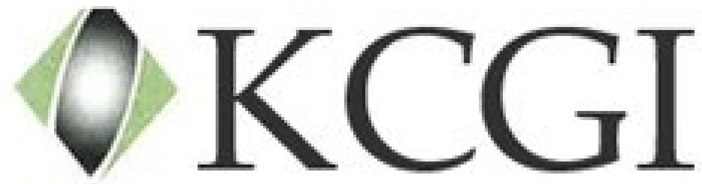
	No	Yes
1. Do you have any of the following new symptoms?		
• Fever and/or chills*		
• Cough*		
• Difficulty breathing/shortness of breath*		
• Sore throat*		
• Sneezing or runny nose*		
• Body aches (other than from an injury)*		
• New loss of taste or smell*		
• New rashes or open sores with fever*		
• Night sweats		
• Severe headache		
• Stiff neck		
• Eye Redness, swelling, or discharge		
• Unexplained bleeding		
• Vomiting or diarrhea		
2. Have you traveled in the past 3 weeks? If yes, where:		
3. Have you had close contact with someone who has traveled in past 3 weeks? If yes, where did they travel:		
4. Have you been in close contact with a person confirmed to have COVID-19?*		

* If the person answers 'yes' they should apply a face mask (if universal masking is not already in place) and be moved to an exam room.
* Follow practice guidelines for masking asymptomatic persons with a history of travel

Office Staff Reviewer: ____________________________________

Check all Actions taken:

No action, screening negative	
Mask applied and cough/handwashing etiquette provided	
Patient isolated from others (moved to room or separated from others)	
Clinical lead notified	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