Southeast Valley Gastroenterology Consultants, P.C. (SEVG)
Demographic Information Form

Name: _____ **Date of Birth:** MM / DD / YYYY
Last First Mi.

Gender: Male ☐ **Female** ☐ **Age:** _____

Street Address: _____

Social Security # XXX - XX - XXXX

City-_____**State-**_____**ZIP**_____

Email:_____

Marital Status: ☐**Married** ☐**Single** ☐**Divorced** ☐**Widowed** ☐**Other**

Race: ☐**White** ☐**Black** ☐**Asian** ☐**Native American/Alaska Native** ☐**Native Hawaiian/Pacific Islander** ☐**Decline** ☐**Unknown**

Ethnicity: ☐**Hispanic/Latino** ☐**Not Hispanic/Latino** ☐**Decline** ☐**Unknown**

Home Phone: XXX - XXX - XXXX **Work Phone:** XXX - XXX - XXXX **Mobile Phone:** XXX - XXX - XXXX

Employer Name: _____ **Occupation:** _____

Primary Care or Referring Doctor: _____ **Doctor's Phone:** XXX - XXX - XXXX

Primary Insurance Information:

Insurance Company Name: _____

Policy Holder: _____ **ID#:** _____ **D.O.B:** MM / DD / YYYY

Secondary Insurance Information:

Insurance Company Name: _____

Policy Holder: _____ **ID#:** _____ **D.O.B:** MM / DD / YYYY

FINANCIAL RESPONSIBILITY/ASSIGNMENT: I agree to pay Southeast Valley Gastroenterology Consultants, P.C. (SEVG), for all services rendered. I understand that bills are payable in full upon the rendering of treatment. I understand that SEVG will make good faith efforts to acquire all needed referrals, authorizations needed to cover services provided and will bill my designated insurance coverage identified above as a courtesy. I assign SEVG all benefits due me for services rendered and expenses incurred under any applicable policy of insurance. I understand that I am financially responsible to SEVG for all charges not covered by this assignment and promise to pay any remaining patient balance due. I understand that any co-pays, deductible or co-insurance will be my responsibility and SEVG will require payment for these amounts prior to visits or services being performed.

COLLECTION POLICY: I understand that a patient balance is considered delinquent if payment in full has not be received within 60 days of the final insurance payment. Delinquent balances may be turned over to a collection agency. Balances sent to a Collection Agency will be assessed a penalty of 30% of the remaining balance. I agree that in the event any patient balance of mine is assessed a collection agency penalty I will pay the 30% Collection Agency Penalty in addition to any patient balance owed to SEVG.

AHCCCS/MEDICAID COVERAGE: I understand that SEVG is not a covered provider under the Arizona Health Care Cost Containment System (AHCCCS) and that they do not accept patients with AHCCCS coverage. I represent by signing this form that I am not covered under an AHCCCS insurance plan. Primarily or secondarily.

INSUFFICIENT FUNDS POLICY: If a personal check is returned to SEVG due to insufficient funds an insufficient funds charge of $50.00 will be applied to your account.

As the patient or authorized representative of the patient I certify that I have read this document and that I agree to the terms of outlined within it.

_____ MM / DD / YYYY

***Patient/Authorized Signature** **Date**

Southeast Valley Gastroenterology Consultants, P.C. (SEVG)

Demographic Information Form

HIPAA CONSENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare Providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physicians' certifications.

I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices and that I may contact this organization at any time to obtain a current copy of this Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I consent to have the following individual(s) involved or notified about my care or treatment:

Name: _____ Phone: XXX - XXX - XXXX___ Relationship to Patient: _____

Name: _____ Phone: XXX - XXX - XXXX___ Relationship to Patient: _____

I consent to be contacted via; Voicemail ☐ Phone Call ☐ Text ☐ Email ☐ for purposes of treatment and/or billing.

I understand that I may revoke this consent in writing at any time, except to the extent that we have acted relying on this consent.

***Patient/Authorized Signature: _____ Date: MM / DD / YYYY**

I wish to have the following individual(s) contacted in case of medical emergency:

Name: _____ Phone: XXX - XXX - XXXX___ Relationship to Patient: _____

Name: _____ Phone: XXX - XXX - XXXX___ Relationship to Patient: _____

☐ **STAT** (If indicated)

875 S. DOBSON RD. CHANDLER, AZ 85224 (480) 899-9800 FAX (480) 899-2994
2730 S. VAL VISTA DRIVE STE. 158 BLDG. 10 GILBERT, AZ 85296 (480) 782-5005

CHARLES M. SCHRON, MD G. ALAN BRACHER, MD MANISH G. AMIN, MD SANDEEP C. PATEL, MD YATIN R. PATEL, MD ANITA E. SPIESS, MD
CHRISTINA SLOAN, PA-C MOLLY WYANT, PA-C JESSICA LAURINO, PA-C JENNIFER SPOHN, PA-C
KELLY M. KOLLMAN, PA-C JENNIFER A. MCPHAIL, PA-C BETHANY A. TENNYSON, PA-C SANDRA L. EHRLER, PA-C MIA RYCKMAN, PA-C

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____, allow Southeast Valley Gastroenterology Consultants, P.C. (SEVG) to release or receive any necessary medical records, including pathology material.

_____ Date:_____/_____/_____
Patient's Signature

Date of Birth:(MM/DD/YYY) _____/_____/_____ SEVG Physician: _____

****

FOR OFFICE USE ONLY:

I authorize Southeast Valley Gastroenterology Consultants P.C. to

☐ **Obtain** information from and/or ☐ **Release** information to:

_____
Name of Provider or Facility

_____
Address

Phone:_____**Fax:**_____

FOR CONTINUITY OF CARE

PLEASE LIMIT RECORDS TO THOSE SPECIFICALLY LISTED BELOW:

Date	Initial Request	2nd Request	3rd Request
Requested for: **CS** **AB** **MA** **SP** **YP** **AS**			

Southeast Valley Gastroenterology Consultants, P.C. (SEVG)

PATIENT INTERVIEW FORM

First Name:_____ **Last Name:**_____

Date of Birth (MM/DD/YYYY): _____

Contact Preference: ☐ Email ☐ Text ☐ Phone ☐ Other_____

Preferred Language: ☐ English ☐ Other _____

I would like to receive preventive care and follow up care reminders. ☐ Yes ☐ No

Medication History:

I consent to obtaining a history of my medications purchased at pharmacies. ☐ Yes ☐ No

Local Pharmacy:_____ **Street Address**:_____

Current Prescription Medications:

Name **Dose** **How taken? (Ex: once daily)**

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Do you take any of the following over-the-counter medications or supplements?

☐	Famotidine (Pepcid AC)	Dose-	How Often-	☐	Aspirin (Excedrin)	Dose-	How Often-
☐	Tagamet (Cimetidine)	Dose-	How Often-	☐	Naproxen (Alleve)	Dose-	How Often-
☐	Ibuprofen (Advil)	Dose-	How Often-	☐	Other:	Dose-	How Often-
☐	Calcium	Dose-	How Often-	☐	Vitamin D	Dose-	How Often-
☐	Iron	Dose-	How Often-	☐	Magnesium	Dose-	How Often-

Allergies: (*Please check ☑ all that apply)* ☐ **I have No Known Drug Allergies**

Latex ☐ Reaction:_____
IV Contrast ☐ Reaction:_____
Iodine ☐ Reaction:_____
Other- _____
Other- _____

Immunizations: (*Please check ☑ all that apply and note the date)*

☐	Flu	When: MM/YYYY	☐	COVID-19	When: MM/YYYY
☐	Hepatitis A	When: MM/YYYY			
☐	Hepatitis B	When: MM/YYYY			
☐	Pneumovax	When: MM/YYYY			

Past or Present Medical Conditions:

(*Please check all that apply)*

GI Conditions:

☐	Colon Polyps	☐	Ulcerative Colitis
☐	Acid Reflux	☐	Crohn's Disease
☐	Duodenal Ulcer	☐	Hepatitis C
☐	Stomach Ulcer	☐	Hepatitis B
☐	Barrett's Esophagus	☐	Irritable Bowel Syndrome
☐	Gallstones	☐	Celiac Disease
☐	Other:	☐	Other:

Rheumatology/Hematology:

☐	Osteoarthritis	☐	Clotting Disorder
☐	Rheumatoid Arthritis	☐	Osteoporosis
☐	Fibromyalgia	☐	Osteopenia
☐	Anemia/Iron Deficiency	☐	Other

Heart/Lung:

☐	Coronary Artery Disease	☐	High Cholesterol
☐	Heart Attack	☐	Stroke
☐	Congestive Heart Failure	☐	Asthma
☐	Valvular Heart Disease	☐	Sleep Apnea
☐	Atrial Fibrillation	☐	COPD
☐	Pacemaker	☐	Valley Fever
☐	Defibrillator	☐	Other:
☐	High Blood Pressure	☐	Other:

Endocrine/Metabolic/Misc.:

☐	Diabetes	☐	Glaucoma	☐	Psoriasis
☐	Hypothyroidism (Under)	☐	Migraines	☐	Other:
☐	Hyperthyroidism (Over)	☐	Depression	☐	Other:
☐	Kidney Disease	☐	Anxiety Disorder	☐	Other:
☐	Kidney Stones	☐	HIV	☐	Other:
☐	Seizures	☐	Dementia	☐	Other:

Cancer:

☐	Colon Cancer	☐	Skin Cancer	When: MM/YYYY
☐	Prostate Cancer	☐	Lung Cancer	When: MM/YYYY
☐	Breast Cancer	☐	Other:	When: MM/YYYY

Diagnostic Studies:

☐	Colonoscopy	When: MM/YYYY	☐	Cardiac Catheterization	When: MM/YYYY
☐	Upper Endoscopy	When: MM/YYYY	☐	Echocardiogram	When: MM/YYYY
☐	Other:	When: MM/YYYY	☐	Other:	When: MM/YYYY

Surgical History: (*Please check all that apply)*

	Appendectomy	When: MM/YYYY		Cardiac Stent	When: MM/YYYY
	Anti-Reflux Surgery	When: MM/YYYY		Coronary Artery Bypass	When: MM/YYYY
	Gastric Bypass	When: MM/YYYY		Aortic Valve Replacement	When: MM/YYYY
	Lap Band	When: MM/YYYY		Mitral Valve Replacement	When: MM/YYYY
	Gallbladder Removal	When: MM/YYYY		Hip Replacement	When: MM/YYYY L or R
	Tonsillectomy	When: MM/YYYY		Knee Replacement	When: MM/YYYY L or R
	Colon Resection	When: MM/YYYY		C-Section	When: MM/YYYY
	Small Bowel Resection	When: MM/YYYY		Hysterectomy	When: MM/YYYY
	Inguinal hernia Repair	When: MM/YYYY		Mastectomy	When: MM/YYYY L or R
	Umbilical hernia Repair	When: MM/YYYY		Other:	When: MM/YYYY
	Incisional Hernia Repair	When: MM/YYYY		Other:	When: MM/YYYY
	Hemorrhoid Surgery	When: MM/YYYY		Other:	When: MM/YYYY

Family Medical History: (*Please check all family members that apply)*

Diagnosis	Mother	Father	Sister	Brother	Daughter	Son	Maternal Grandfather	Maternal Grandmother	Paternal Grandfather	Paternal Grandmother	Maternal Aunt	Maternal Uncle	Paternal Aunt	Paternal Uncle
Colon Cancer														
Colon Polyps														
Liver Cancer														
Esophagus Cancer														
Stomach Cancer														
Pancreas Cancer														
Ovarian Cancer														
Uterine Cancer														
Kidney Cancer														
Crohn's Disease														
Ulcerative Colitis														
Celiac Disease														
Alcoholism														
Liver Disease														
Lynch Syndrome (HNPCC)														
Familial Adenomatous Polyposis Syndrome														
Other:														
Other:														
Other:														
Other:														

Social History:

Occupation:_____ Retired? ☐ Yes ☐ No

Number of Children:_____

Marital Status: (*Please check the one that applies)*

☐ Single ☐ Married ☐ Widowed

Alcohol: ☐ None

Drink Type _____ How Many_____ Per: Day / Week / Month / Year

Tobacco: ☐ Every Day Smoker ☐ Some Day Smoker ☐ Former Smoker ☐ Never Smoker

Tobacco Type _____ How Many_____ Per: Day / Week / Month / Year

Illicit Drug Use: ☐ None

Drug Type _____ How Many_____ Per: Day / Week / Month / Year

Marijuana/Cannabis Use: ☐ None

Route (Smoke/Edible) _____ How Many_____ Per: Day / Week / Month / Year

Review of Symptoms: (Please check all that apply)

Constitutional

- ☐ loss of appetite
- ☐ memory loss
- ☐ fatigue
- ☐ difficulty sleeping
- ☐ excessive sweating
- ☐ weight gain
- ☐ weight loss
- ☐ fever

Cardiovascular

- ☐ palpitations
- ☐ fainting
- ☐ dizziness
- ☐ shortness of breath with activity
- ☐ swelling of feet/ankles
- ☐ heart murmur
- ☐ chest pain

Gastrointestinal

- ☐ heartburn
- ☐ difficulty swallowing
- ☐ bloating
- ☐ belching
- ☐ nausea
- ☐ vomiting
- ☐ vomiting blood
- ☐ abdominal pain
- ☐ constipation
- ☐ diarrhea
- ☐ stool urgency
- ☐ black stools
- ☐ rectal bleeding
- ☐ pain in rectum
- ☐ incontinence of stool
- ☐ change in bowel habits

Musculoskeletal

- ☐ joint pain
- ☐ muscle aches
- ☐ back pain
- ☐ joint swelling

Psychiatric

- ☐ depression
- ☐ cries often
- ☐ worries excessively
- ☐ panic attacks
- ☐ anxiety

Respiratory

- ☐ chronic cough
- ☐ productive cough
- ☐ coughs up blood
- ☐ shortness of breath