Appt. Date: _____

Check in Time: _____

Appt. Time: _____

With Dr._____

Centers for Gastroenterology

Northern Colorado's Leader in Digestive Health Care for 25 Years

Welcome and thank you for choosing the **Centers for Gastroenterology** to provide your health care needs.

The physicians and staff of the **Centers for Gastroenterology** want your initial visit and ongoing relationship to progress as smoothly as possible. Be assured that if you identified a primary care or referring physician, our specialists will work closely with him/her in the diagnosis of your condition and in determining a plan of care. To that end, we request some assistance from you:

Please fill out the attached medical history form and patient information forms. You will get the most out of your visit by having your medical history completed, knowing the medications you are presently using, thinking of questions you have for the doctor, and being aware of any prescriptions refills you may need soon.

Medical records, lab reports and/or x-rays from your primary physician may be required for your visit. We will request these records for you at the time you schedule your appointment. However, if the referring office does not send the records, please be aware that your appointment may need to be rescheduled.

We do request payment for services at the time of your visit. Depending on your insurance coverage, this may be the entire fee, or it may be a visit co-payment. Our office takes payments by VISA, Master Card, Discover and American Express as well as a personal check or cash.

Please be sure to bring your insurance cards (and referral form, if your insurance company requires one) with you at the time of your visit. New identification protection regulations require photo identification on every visit: please bring a driver's license or state issued identification.

The Patient is responsible for notifying our office within two (2) business days to cancel an office appointment or within three (3) business days to cancel a scheduled procedure. A fee of $50 will be charged for office visit no shows or failure to cancel an office visit in 48 hours and a fee of $300 will be charged for no shows for scheduled procedures. Insurance will not cover these fees.

If you fail to show up on your initial office visit, a deposit of $100 will be required before you will be rescheduled for your visit. The $100 will be applied towards any balance due to the Centers for Gastroenterology. Any amount remaining after the balance due is paid will be refunded to you. If you no show again, you will not be rescheduled.

Our staff and our physicians are committed to providing you the best care and attention. We believe that a caring practice means taking time to get to know our patients and being sensitive to and aware of your needs. Please visit our website at **www.digestive-health.net** to learn more about our clinic. We sincerely look forward to meeting you.

Sincerely,
Centers for Gastroenterology

3702 S. Timberline Road
Fort Collins, CO 80525
970-207-9773

8225 W. 20th Street
Greeley, CO 80634
970-378-1414

2555 E. 13th Street, Ste. 220
Loveland, CO 80537
970-669-5432

Date of appointment: _____

Patient name: _____ Date of birth: _____ Age: _____

Primary care provider: _____ Referring provider: _____

Reason for Visit: _____

Preferred local pharmacy: _____ **Preferred mail order pharmacy: _____**

Preferred laboratory for blood work: _____ **Preferred radiology facility: _____**

HT _____ **Weight _____** **BP _____/_____** **Pulse _____**

Immunizations: Flu/When?☐/ **(65 or older) Pneumovax/When?☐/**

Fallen within the last 3 months? Yes☐ No☐ **Fear of falling? Yes☐ No☐** **Difficulty ambulating? Yes☐ No☐**

Patient Review of Systems

Please mark any condition with which you have had significant problems in the last 6 months:

Constitution
- ☐ Chills
- ☐ Diaphoresis (Night sweats)
- ☐ Fatigue
- ☐ Fever
- ☐ ***Loss of appetite***
- ☐ ***Weight loss***
- ☐ ***Weight gain***

HEENT
- ☐ Eye pain
- ☐ Trouble swallowing
- ☐ ***Yellow eyes***

Respiratory
- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ ***Excessive snoring***
- ☐ ***Hoarseness***

Cardiovascular
- ☐ Chest pain
- ☐ Palpitations

Gastrointestinal
- ☐ Abdominal distention
- ☐ Abdominal pain
- ☐ Blood in stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting
- ☐ ***Black stool***
- ☐ ***Change in bowel habits***
- ☐ ***Difficulty swallowing***
- ☐ ***Gas/flatulence***
- ☐ ***Heartburn/indigestion***
- ☐ ***Bowel accidents***
- ☐ ***Reflux***
- ☐ ***Vomiting blood***

Genitourinary
- ☐ Pain on urination (Dysuria)
- ☐ Flank pain
- ☐ Blood in urine (Hematuria)

Musculoskeletal
- ☐ Back pain
- ☐ Arthralgia's (Joint pain)

Skin
- ☐ Rash
- ☐ Color changes (Yellow skin)

Neurological
- ☐ Dizziness
- ☐ Headaches
- ☐ Light-headedness
- ☐ Seizures
- ☐ Weakness

Hematological
- ☐ Enlarged lymph nodes (Adenopathy)
- ☐ Bruises/bleeds easily

Psychiatric
- ☐ Behavior problems (Depression)
- ☐ Nervous/anxious
- ☐ Sleep disturbances

Patient name: _____ Date of birth: _____

Immunizations:

	Y/N	Date last received
Flu Vaccine		
If 65 or older, Pneumococcal Vaccine		

Please update any new medications or allergies since we last saw you in our office:

Medications:

Medication Name	Dose	Frequency

Medication Allergies:

Name of allergen	Reaction/Date of Onset

Social History

Tobacco Use: Y ☐ N ☐ Former ☐ Packs/day: _____ Quit date: _____

Smokeless Tobacco: Y ☐ N ☐ Former ☐ Type: Chew ☐ Snuff ☐ Quit date: _____

Alcohol use: Y ☐ N ☐ Former ☐

Drinks per week: ____ glasses of wine ____ cans of beer ____ shots of liquor

Drug Use:

Y ☐ N ☐ Former ☐ **Types:** ☐ marijuana ☐ methamphetamine ☐ cocaine ☐ IV

Other:

_____

_____

Caffeine use: Y ☐ N ☐ Former ☐ Amount/Day: _____ Type: _____