Premier Gastroenterology, PA
12102 Cortez Blvd, Brooksville, FL 34613
(352) 597 – 4000 ☎
(352) 597 – 0550
premgastro.com

New Patient Registration

(Please print clearly and fill out the questionnaire completely)

Today's Date: _____

Patient Name (Last, First, M.I.)_____

Previous Name (Last, First)_____

Address (Street) _____

City_____ State _____ Zip Code _____

Home Phone (____)_____Cell (____)_____ Work (____)_____

Which is the best number to reach you? (H) (C) (W) Email_____

Primary Care Physician _____ Phone (____)_____

Date of Birth _____/_____/_____ Sex ( )Male ( )Female

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widow/er ☐Other

Social Security # _____-____-_____ Employer _____

Emergency Contact

Name & Relationship _____ Phone (____)_____

Address _____

Insurance Information and Responsible Party

Primary Insurance Company _____ID_____

Secondary Insurance Company _____ID_____

Demographics

RACE: ☐White ☐Black or African American ☐Asian ☐American Indian or Alaska Native
☐Native Hawaiian or Pacific Islander ☐Other ☐Declined to specify

ETHNICITY: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Declined to specify

PRIMARY LANGUAGE: ☐English ☐Spanish ☐Other, please specify_____

Pharmacy Name _____ Phone number _____
Address _____

REASON FOR VISIT_____

_____

PAST MEDICAL HISTORY (*Conditions that YOU have been diagnosed with*)

Gastrointestinal

☐Heartburn/GERD	☐Barrett's esophagus	☐Hiatal hernia	☐Gastritis
☐Gastric ulcer	☐H. pylori	☐Gallstones	☐Pancreatitis
☐Abnormal liver tests	☐Fatty liver	☐Cirrhosis	☐Hepatitis
☐Celiac disease	☐Ulcerative colitis	☐Crohn's disease	☐Colon polyp
☐Irritable bowel disease	☐Diverticulosis	☐Diverticulitis	☐Hemorrhoids
☐Esophageal cancer	☐Pancreatic cancer	☐Liver cancer	☐Colon cancer

Cardiovascular

☐High blood pressure	☐High cholesterol	☐Congestive heart failure	☐Heart attack
☐Atrial fibrillation	☐Rhythm disorder	☐Heart valve disease	☐Angina

Pulmonary

☐Sleep apnea	☐Asthma	☐Emphysema/COPD	☐Pneumonia
☐Pulmonary embolism	☐Sarcoidosis	☐Lung cancer	

Neuropsychiatric

☐Stroke or TIA	☐Migraines	☐Neuropathy	☐Seizure
☐Dementia	☐Parkinson's	☐Depression	☐Anxiety
☐Obsessive compulsive	☐Bipolar disorder	☐Schizophrenia	

Endocrine

☐Diabetes	☐Hypothyroid	☐Hyperthyroid	☐Thyroid cancer

Genitourinary

☐Kidney disease	☐Kidney stones	☐Prostate hypertrophy	☐Bladder cancer
☐Prostate cancer	☐Polycystic ovarian	☐Endometriosis	☐Uterine fibroids
☐Ovarian cancer	☐Uterine cancer	☐Cervical cancer	☐Endometrial cancer

Musculoskeletal

☐Osteoarthritis	☐Rheumatoid arthritis	☐Fibromyalgia	☐Chronic back pain
☐Osteoporosis	☐Osteopenia	☐Lupus	☐Gout

Head/Skin

☐Glaucoma	☐Allergic rhinitis	☐Basal cell cancer	☐Psoriasis
☐Eczema	☐Melanoma	☐Squamous cell cancer	

Hematologic

☐Anemia	☐Blood transfusion	☐Blood clot	☐Hemochromatosis
☐Leukemia	☐Lymphoma		

☐Any other conditions not previously mentioned_____

ALLERGIES

☐NONE ☐Sulfa ☐Penicillin ☐Aspirin ☐Tape ☐Latex ☐Iodine

Other_____

PREVIOUS SURGERIES AND PROCEDURES

☐Gallbladder	☐Appendix	☐Groin hernia repair	☐Abdomen hernia repair
☐Adhesion surgery	☐Colon resection	☐Hemorrhoid surgery	☐Anti-reflux surgery
☐Weight loss surgery	☐D & C	☐Uterine ablation	☐C-section
☐Tubal ligation	☐Total hysterectomy	☐Partial hysterectomy	☐Back surgery
☐Prostate surgery	☐Breast augmentation	☐Lumpectomy	☐Mastectomy
☐Stent/angioplasty	☐Heart bypass surgery	☐Heart valve surgery	☐Pacemaker
☐Defibrillator	☐Carotid surgery	☐vascular surgery	☐Neck surgery

☐Any other surgeries not previously mentioned_____

FAMILY HISTORY *Alive, Deceased,*

	Age	*Unknown*	*Medical Conditions*
Father:	_____	_____	_____
Mother:	_____	_____	_____
Siblings:	# of brothers	_____	_____
	# of sisters	_____	_____

Children: How many sons _____ How many daughters _____ Healthy? _____

SOCIAL HISTORY

Marital Status: ☐Single ☐Married ☐Divorced ☐Widow/er ☐Other

Lives with: ☐Alone ☐Spouse ☐Children ☐Friend ☐Other

Work: ☐Full-time ☐Part-time ☐Retired ☐Disabled ☐Unemployed ☐Student

Occupation _____

Smoker: ☐Never

☐Current -- How many per day? _____ For how long? _____

☐Former –- Year quit? _____Years smoked/how much?_____

Alcohol: How many drinks at a time? _____ How often?_____

☐Never used

☐Quit drinking—when? _____

Drug Use: ☐Never used

☐History of IV drug use or illicit drug use _____

Tattoos: ☐None ☐Yes – done personally or professionally? _____

Blood transfusion: ☐Never ☐Yes – year_____ # of units_____

Donated blood: ☐Never ☐Yes – year_____

REVIEW OF SYSTEMS *(Do you have current or persistent problem with any of the following?)*

Hematological:
☐bleeding or bruising tendency
☐anemia
☐past transfusion
☐swollen glands

Gastroenterology:
☐poor appetite
☐belching
☐incomplete evacuation
☐painful swallowing
☐difficulty swallowing
☐heartburn
☐nausea
☐vomiting
☐bloating
☐constipation
☐diarrhea
☐blood in stool
☐abdominal pain
☐change in bowel habits
☐rectal bleeding

General:
☐recent weight change
☐fever/night sweats
☐fatigue/weakness
☐loss of appetite

Dermatology:
☐rash
☐itching

Endocrinology:
☐heat or cold intolerance
☐excessive thirst
☐hair loss
☐excessive sweating
☐fatigue

Neurology:
☐headache
☐tremor
☐lightheaded/dizziness
☐numbness/tingling
☐seizure

Ophthalmology:
☐blurred vision
☐contact with irritant
☐wears contact
☐wears glasses
☐eye disease
☐diminished vision
☐drainage from eyes

ENT/Respiratory:
☐hearing loss
☐shortness of breath
☐ringing in ears
☐nose bleeds
☐sore throat
☐voice change
☐chronic cough

Cardiology:
☐chest pain
☐leg pain with walking
☐palpitations
☐shortness of breath
☐swelling of ankles
☐dizziness

Musculoskeletal:
☐joint pain
☐back pain
☐joint swelling
☐joint stiffness
☐leg cramps

Psychiatric:
☐memory loss or confusion
☐depression
☐anxiety
☐tension/stress
☐sleep disturbances

Genitourinary:
☐difficulty with urinating
☐urinary incontinence
☐excessive urination
☐urinating >1 time during night
☐blood in urine

MEDICATION LIST

Patient Name:_____ Date:_____

(Please include all PRN, vitamins, and other over the counter medications)

NAME	DOSAGE	# OF TIMES A DAY	REASON

Premier Gastroenterology, PA
M. Rodwan Hiba, MD
Required Signatures

Consent for Treatment:
My signature below indicates that I hereby consent to any recommended medical service provided to me by Premier Gastroenterology, PA and Dr. M. Rodwan Hiba. I acknowledge that no guarantees have been made to me as a result of examination or treatment provided.

Insurance Statement (All Insurances):
I understand that as a courtesy Premier Gastroenterology, PA will bill my insurance carrier for services rendered. I request that payment of authorized insurance benefits be made on my behalf to Premier Gastroenterology, PA for any services furnished. I authorize any holder of medical information about me be released to the insurance carrier/Health Care Finance Administration and its agents to determine benefits payable for related services. I also request that payment for authorized Medigap/Secondary insurance carrier benefits be made on my behalf to Premier Gastroenterology, PA. I authorize any holder of medical information about me be released to the Medigap/Secondary insurance carrier and its agents to determine benefits payable for related services. I understand that I do not need to provide my Medigap/Secondary insurance carrier with information concerning Medicare claims because my signing this authorization will allow Medicare payment information to cross-over automatically.

All Patients (Required):
I understand that I am financially responsible and agree to all charges for myself and for the members of my family, as applicable, promptly upon presentation thereof. *I understand that payment of copays, coinsurance and deductibles are due at the time of service and that if I am unable to do so, then my appointment may be rescheduled.* I understand that it is my responsibility to verify and understand my insurance policy PRIOR to receiving the medical services provided. If paying by check, I understand that there is a $35.00 fee for any returned check. Charges as shown by statements are agreed to be correct unless protested in writing within thirty days of date of service. It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon. In the event that legal action should become necessary to collect unpaid balance due, I agree to pay reasonable attorney's fees and other such costs as determined by the Hernando County Court. I UNDERSTAND AND AGREE THERE WILL BE A $35.00 NO SHOW FEE FOR OFFICE VISITS NOT CANCELLED WITHIN 24 HOURS. IN ADDITION, THERE WILL BE A $75.00 NO SHOW FEE FOR PROCEDURES NOT CANCELLED WITHIN 36 HOURS OF THE PROCEDURE.

Rx History Consent:
I hereby give Premier Gastroenterology, PA permission to view my prescription information and history from all external sources. By signing this consent form you are agreeing that Premier Gastroenterology can request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payers for all treatment purposes.

Understanding all of the above, I hereby provide informed consent to Premier Gastroenterology, PA.

_____ _____
Patient's Signature/ Representative Date

_____
Print Name

Premier Gastroenterology PA

CONSENT TO DISCLOSE MEDICAL INFORMATION

Patient Name:_____DOB:_____

Please check one of the following:

_____I give my permission to the employees of Premier Gastroenterology to disclose my Protected Health Information to me and the following family or friends:

Name:_____Relation:_____Phone:_____

Address:_____

Name:_____Relation:_____Phone:_____

Address:_____

Name:_____Relation:_____Phone:_____

Address:_____

Name:_____Relation:_____Phone:_____

Address:_____

____I request that all my Protected Health Information be disclosed ONLY to me and no other family or friends.

I understand that I may revoke or change this Consent at any time by filling out another consent form to replace this one.

_____Date:_____

Patient Signature

_____

Patient- Print Name

Premier Gastroenterology, PA *M. Rodwan Hiba, MD*
American Board Certified in Internal Medicine & Gastroenterology

RELEASE OF MEDICAL INFORMATION

To: _____

_____

_____

I hereby authorize you to release any medical information, including but not limited to, examinations, diagnosis, and medical records of any treatment rendered to me to:

Dr. M. Rodwan Hiba
Premier Gastroenterology, PA
12102 Cortez Blvd
Brooksville, Florida34613

_____ _____
PATIENT SIGNATURE GUARDIAN SIGNATURE (IF MINOR)

_____ _____
WITNESS DATE

Patient name _____

Social Security Number_____ Date of Birth _____

Please Provide Photocopies of:

- ❑ All records (any patient diagnostic medical information, as well as, H & P, consultation, operative reports, discharge summery, etc.
- ❑ Colonoscopy and pathology reports
- ❑ Upper endoscopy and pathology reports
- ❑ Laboratory reports
- ❑ X-rays, CT scans, MRI reports
- ❑ Other _____

_____