

**GASTROENTEROLOGY CENTER OF THE MIDSOUTH, P.C.
G.I. DIAGNOSTIC & THERAPEUTIC CENTER, L.L.C.**

**Orin L. Davidson, III, M.D.
Michael S. Dragutsky, M.D.
Raif W. Elsagr, M.D.
Daniel E. Griffin, M.D.
Christopher M. Griffith, M.D.
William G. Hardin, M.D.
Rolando J. Leal, M.D.**

**Randolph M. McCloy, M.D.
Eric J. Ormseth, M.D.
Mary C. Portis, M.D.
Anca I. Pop, M.D.
Geza Remak, M.D.
James H Rutland, III, M.D.
Alan D. Samuels, M.D.**

**David D. Sloas, M.D.
Carles R. Surles, Jr. M.D.
W. Zachary Taylor, M.D.
John D. Ward, M.D.
Robert S. Wooten, M.D.
Ziad H. Younes, M.D.
Chantil D. Jeffreys, R.N., F.N.P.**

Please complete the following forms and bring them with you when you come for your procedure.

ACCOUNT # _____ DR. CODE _____

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GUARANTOR INFORMATION

GUARANTOR

NAME: (first) _____ (middle initial) _____ (last) _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE : (_____) _____ - _____ SPOUSE NAME: _____

GUARANTOR SOCIAL SECURITY #: _____

PATIENT INFORMATION

PATIENT

NAME: (first) _____ (middle initial) _____ (last) _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE:(_____) _____ - _____ CELLULAR PHONE:(_____) _____ - _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

EMERGENCY PHONE:(_____) _____ - _____ EMAIL _____

BIRTH DATE: _____ / _____ / _____ SEX: _____ MARITAL STATUS: _____

SOCIAL SECURITY #: _____ RACE: _____

EMPLOYER NAME: _____

EMPLOYER ADDRESS: _____

EMPLOYER CITY: _____ STATE: _____ ZIP CODE: _____ COUNTY: _____

EMPLOYER PHONE:(_____) _____ - _____ EXT: _____

PRIMARY INSURANCE INFORMATION

CHARGES FOR ALL SERVICES ARE THE RESPONSIBILITY OF THE PATIENT/GUARANTOR. PLEASE BE INFORMED THAT WE LOOK TO YOU FOR PAYMENT IF YOUR INSURANCE COMPANY DOES NOT PAY YOUR CLAIM.

PRIMARY INSURANCE

INSURANCE COMPANY NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

GROUP #: _____ POLICY #: _____ CO PAY: _____

PATIENT RELATIONSHIP TO POLICYHOLDER: _____

PRIMARY INSURANCE POLICYHOLDER INFORMATION

POLICYHOLDER

NAME: (first) _____ (middle initial) _____ (last) _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE : (_____) _____ - _____ BIRTH DATE: _____ / _____ / _____ SEX: _____

SOCIAL SECURITY#: _____ POLICYHOLDER EMPLOYER PHONE:(____) _____ EXT: _____

POLICYHOLDER EMPLOYER NAME: _____

POLICYHOLDER EMPLOYER ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

GROUP #: _____ POLICY #: _____ CO PAY: _____

SECONDARY INSURANCE POLICYHOLDER INFORMATION

POLICYHOLDER

NAME:(first) _____ (middle initial) _____ (last) _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE : (_____) _____ - _____ BIRTH DATE: _____ / _____ / _____ SEX: _____

SOCIAL SECURITY# _____ - _____ - _____ POLICYHOLDER EMPLOYER PHONE:(____) _____ EXT: _____

POLICYHOLDER
EMPLOYER: _____

POLICYHOLDER EMPLOYER ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PATIENT RELATIONSHIP TO POLICYHOLDER: _____



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For Office Use Only - Please fax or mail medical records for:
 Patient Name: _____ SSN _____ to location indicated below.

- | | | |
|---|--------------------|--|
| <input type="checkbox"/> 6005 Park Ave., #323B, Memphis, TN 38119 | Fax (901) 684-5518 | Office (901) 684-5500 |
| <input type="checkbox"/> 1324 Wolf Park Dr., Germantown, TN 38138 | Fax (901) 755-4321 | Office (901) 755-9110 |
| <input type="checkbox"/> 7668 Airways Blvd. Building B, Southaven, MS 38671 | Fax (662) 349-6634 | TN #Office (901) 766-9490
MS #Office (662) 349-6950 |
| <input type="checkbox"/> 1407 Union, #1400 Memphis, TN 38104 | Fax (901) 272-1786 | Office (901) 272-9296 |
| <input type="checkbox"/> 1310 Wolf Park Dr. Germantown, TN 38138 | Fax (901) 624-5280 | Office (901) 624-5151 |
| <input type="checkbox"/> 3350 N. Germantown Road Bartlett, TN 38133 | Fax (901) 377-5105 | Office (901) 377-2111 |

APPOINTMENT REQUEST (Please check one)

[] SELF REQUESTED - You have asked to see a GCMS physician or your physician has recommended one of the physicians at the Gastroenterology Center of the MidSouth.

[] PHYSICIAN REQUESTED - Name of the physician requesting an evaluation from a GCMS physician. _____

CONSENT FOR CARE

The physicians & staff of the Gastroenterology Center of the MidSouth, P.C. &/or the G.I. Diagnostic and Therapeutic Center, L.L.C. will be hereafter referred to as "the GI Center". I hereby give my consent for treatment.

My signature indicates I have read and understand the information on the front and back of this form. I understand I will receive a personal medical identification number and all calls to the GI Center to discuss my health information will require my personal identification number.

Signature _____ Date _____

EMERGENCY CARE

DO YOU HAVE A LIVING WILL? () YES () NO

In the event of a life threatening emergency, it is the policy of the GI Center to perform Cardiopulmonary Resuscitation (CPR) as necessary to stabilize our patients for transfer to an acute care health facility.

FINANCIAL POLICY

We are committed to providing our patients with the best possible care. If you have medical insurance, we will do all that we can to help you receive your maximum allowable benefit. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

We will file your insurance claim for you; however, we ask that you pay any co-payment or deductible at the time our services are rendered and the balance in full within 90 days regardless of insurance filing. We accept Cash, Check, MasterCard, or Visa. We realize temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. If your account is turned over to a professional collection agency you will be dismissed from care by physicians employed by Gastroenterology Center of the MidSouth, P.C. &/or G.I. Diagnostic & Therapeutic Center, L.L.C.

If you have any questions about the above information, or any uncertainty regarding insurance coverage, please do not hesitate to ask. We are here to help you.

I have read and understand this explanation of the financial policy of the GI Center and hereby authorize the release of any medical information deemed necessary to process any insurance claim for services rendered. This form is authorization for all medical benefits from any insurance company on said claims to be paid directly to Gastroenterology Center of the MidSouth, P.C. &/or G.I. Diagnostic & Therapeutic Center, L.L.C.

MEDICARE EXTENDED PAYMENT REQUEST (one time authorization)

I request payment of authorized Medicare benefits to be made either to me or on my behalf to: the physicians of the Gastroenterology Center of the MidSouth, P.C., and/or G. I. Diagnostic & Therapeutic Center, L.L.C. for any services provided me. I authorize any holder of medical information about me, to release to the Center for Medicare and Medicaid Services and its agents, any information needed to determine these benefits or the benefits payable for related services.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

My signature on this form indicates I have received a copy of the "Notice of Privacy Practices" from the GI Center and I understand how my health care information will be used and /or disclosed.

COMMUNICATIONS REGARDING YOUR HEALTH CARE INFORMATION

Please indicate with whom we may discuss your healthcare. Check all that apply.

- The GI Center may communicate information regarding my healthcare with anyone living at my residence.**

- The GI Center may communicate information regarding my healthcare with the individuals listed below:**

Name _____	Relationship _____
Name _____	Relationship _____
Name _____	Relationship _____

- The GI Center may not communicate my healthcare information with anyone other than me.**

Medical and Family History Form

Name _____ Today's Date _____ Chart # _____

Birthdate _____ Reason For Visit _____

Allergies

None
 Aspirin
 Iodine
 Penicillin
 Sulfa
 Versed
 Eggs
 Latex
 Other _____

Past Illnesses

<input type="checkbox"/> None	<input type="checkbox"/> Stomach/Duod. Ulcer	<input type="checkbox"/> Anemia	<input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> Ulcerative Colitis	<input type="checkbox"/> Blood Transfusions	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Colon Polyps	<input type="checkbox"/> Chronic Headache	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Chronic Pain (>6 mos)	<input type="checkbox"/> Endometriosis
<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Sexually transmitted disease	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Frequent Urinary Infections
<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Seizures	<input type="checkbox"/> TB or Positive TB skin test	<input type="checkbox"/> Lupus	<input type="checkbox"/> Kidney disease/failure
<input type="checkbox"/> Esophagitis/GERD	<input type="checkbox"/> Stroke or Paralysis	<input type="checkbox"/> Arterial Blockages	<input type="checkbox"/> Melanoma	<input type="checkbox"/> Kidney Stones
<input type="checkbox"/> Gallstones	<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Ovarian Cysts
<input type="checkbox"/> Groin Hernia	<input type="checkbox"/> Colon Cancer	<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Ovarian Cancer	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Irritable Bowel	<input type="checkbox"/> Abnormal Bleeding	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Asthma	<input type="checkbox"/> Other _____
<input type="checkbox"/> Pancreatitis	<input type="checkbox"/> Abnormal Blood Clotting	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Emphysema/COPD	

Previous Operations or Treatments

<input type="checkbox"/> None	<input type="checkbox"/> Colonoscopy	<input type="checkbox"/> ERCP	<input type="checkbox"/> Ovary	<input type="checkbox"/> Tubal Ligation
<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Capsule Endoscopy	<input type="checkbox"/> Colon Polyp Removal	<input type="checkbox"/> Radiation Therapy-Head/Neck	<input type="checkbox"/> Radiation Therapy-Chest
<input type="checkbox"/> Cardiac (CABG)	<input type="checkbox"/> C-Section	<input type="checkbox"/> Liver Biopsy	<input type="checkbox"/> Radiation Therapy-Abdomen	<input type="checkbox"/> Radiation Therapy-Ovary
<input type="checkbox"/> Cardiac (Valve)	<input type="checkbox"/> Gallbladder	<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Radiation Therapy-Prostate	<input type="checkbox"/> Other _____
<input type="checkbox"/> Colon Resection	<input type="checkbox"/> Groin Hernia	<input type="checkbox"/> Joint Replacement	<input type="checkbox"/> Prostate Surgery	
<input type="checkbox"/> Colostomy	<input type="checkbox"/> Hemorrhoid	<input type="checkbox"/> Kidney	<input type="checkbox"/> Stomach	
<input type="checkbox"/> Upper/EGD	<input type="checkbox"/> Hiatal Hernia	<input type="checkbox"/> Obesity Surgery	<input type="checkbox"/> Thyroid	

Social History Marital Status:

Single Separated
 Divorced Widowed

Alcohol Use:

Never Quit
 1 or fewer drinks/week 2 or more drinks/week

Cigarette Use:

Never Quit
 20 or fewer cigarettes/day More than 1 pack/day

Social History Occupation:

Patient Occupation _____

Veteran

REVIEW OF SYSTEMS

Gastrointestinal:

- | | | | | |
|---|---|--|---|--------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Change in Bowel Habits | <input type="checkbox"/> Painful Swallowing | <input type="checkbox"/> Painful Stools | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Constipation | <input type="checkbox"/> Flatulence/Rectal Gas | <input type="checkbox"/> Rectal Bleeding | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Belching | <input type="checkbox"/> Dairy Intolerance | <input type="checkbox"/> Heartburn/Reflux | <input type="checkbox"/> Rectal protrusions | |
| <input type="checkbox"/> Black Stools | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Mucus in Stools | <input type="checkbox"/> Rectal Urgency | |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Nausea | <input type="checkbox"/> Soiling/Incontinence | |

Genitourinary:

- | | |
|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Burning on Urination |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Other _____ |

Skin:

- | | |
|-----------------------------------|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Suspicious Lesions |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Other _____ |

Cardiovascular:

- | | | |
|---|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Ankle Swelling | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> Other _____ |

Neurological:

- | | |
|------------------------------------|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Frequent Headaches |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of Consciousness |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Other _____ |

Endocrine:

- | | |
|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Heat Intolerance |
| <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cold Intolerance | |

Constitutional:

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Weight Gain |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Loss of Appetite | |

Psychiatric:

- | | |
|--|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Difficulty Sleeping |
| <input type="checkbox"/> Anxiety/Panic | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Depression | |

Eyes:

- | | |
|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Visual Decline |
| <input type="checkbox"/> Light Sensitivity | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Eye Pain | |

Hematologic:

- | | |
|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Abnormal Blood Clotting |
| <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Prolonged Bleeding | |

Ears, Nose and Throat:

- | | |
|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Sore Throat |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Nose Bleeds |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Other _____ |

Musculoskeletal:

- | | |
|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Muscle Pain |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Joint Pain | |

Respiratory:

- | | |
|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Painful Breathing |
| <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Chronic Cough | |

FAMILY HISTORY

	Father	Mother	Child(ren)	Brother(s)	Sister(s)
Healthy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deceased	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Celiac Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
age at diagnosis	_____	_____	_____	_____	_____
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
age at diagnosis	_____	_____	_____	_____	_____
Colon Polyps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
age at diagnosis	_____	_____	_____	_____	_____
Esophageal Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
age at diagnosis	_____	_____	_____	_____	_____
Ovarian Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
age at diagnosis	_____	_____	_____	_____	_____
Pancreatic Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
age at diagnosis	_____	_____	_____	_____	_____
Stomach Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
age at diagnosis	_____	_____	_____	_____	_____
Uterine Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
age at diagnosis	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____

Please list any prescription medications you currently are taking and how often:
