PLEASE PRINT

PATIENT_____DATE OF BIRTH_____AGE_____

ADDRESS_____CITY/STATE_____ZIP_____

SOCIAL SECURITY #_____MARITAL STATUS: S / M / D / W GENDER: Male / Female

HOME #_____WORK #_____CELL #_____

YOUR EMAIL ADDRESS FOR **PATIENT PORTAL ACCESS**_____

RACE (circle one): African American Hispanic Caucasian Other: _____REFUSE TO REPORT

ETHINICITY (circle one): Non-Hispanic Hispanic Other: _____ REFUSE TO REPORT

LANGUAGE: English Spanish Sign Language Other: _____

EMPLOYED BY_____OCCUPATION_____

SPOUSE_____EMPLOYED BY_____WK #_____

RESPONSIBLE PARTY (if different from above) _____

ADDRESS_____

EMPLOYED BY_____ PHONE #_____

EMERGENCY CONTACT (other than spouse or parent) _____

REFERRED BY _____

Pharmacy Information
Name of Pharmacy:
Location:
Rx ID:

ALEXANDRIA GASTROENTEROLOGY ASSOCIATES

REQUIRED SIGNATURES

ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION (ALL INSURANCES):

I request that payment of authorized insurance benefits be made on my behalf to Alexandria Gastroenterology Associates for any services furnished. I authorize any holder of medical information about me to be released to the insurance carrier 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 Alexandria Gastroenterology Associates. I authorize any holder of medical information about me be released to Medigap/Secondary insurance carrier and its agents to determine benefits 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 of this authorization will allow Medicare payment information to cross-over automatically.

Signature: _____ **Date:** _____

ALL PATIENTS (REQUIRED):

I understand that as a courtesy Alexandria Gastroenterology Associates will bill my insurance carrier for services rendered. 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. 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 of the pendency of claims thereon. In the event, legal action should become necessary to collect an unpaid balance due. I agree to pay reasonable attorney fees and other such costs as determined by the court.

Signature: _____ **Date:** _____

CONSENT TO OBTAIN EXTERNAL Rx HISTORY:

I_____ whose signature appears below, authorize Alexandria Gastroenterology Associates and its affiliated providers to view my external prescription history via the RxHub services. I understand that prescription history from multiple other unaffiliated medical providers and staff here, and it may include prescriptions back in time for several years.

Signature: _____ **Date:** _____

ACKNOWLEDGEMENT OF HIPAA:

I _____ whose signature appears below, have the right to review the Notice of Privacy Practices prior to signing this consent. **Cenla Family Medicine Associates, LLC, Central Louisiana Foot and Ankle Specialists, Cardiac and Vascular Services of Cenla and Alexandria Gastroenterology Associates** reserve the right to revise their Notice of Privacy Practices at any time. A revised notice of Privacy Practices may be obtained by forwarding a written request to office manager, 1587 North Bolton Ave., Suite 1100, Alexandria, La 71303.

Signature: _____ **Date** _____

HIPAA Release Form for Individuals Involved in Care of Patient:

I, give Dr. Hollier and Kimberly Sills, FNP-C permission to speak with the following people regarding my health status, including diagnosis, treatment options and plans and payments for health services that I receive from A. G. A.

**[ ] NONE. My medical records are not to be released to anyone.

This consent is valid until such time as I provide A. G. A. written revocation of it.

Dr. Hollier and Kimberly Sills, FNP-C may speak with:

Name: _____

Relationship: _____ **Phone:**

_____

Name: _____

Relationship: _____

Phone: _____

Name: _____

Relationship: _____

Phone: _____

Name: _____

Relationship: _____ **Phone:**

_____

Name: _____

Relationship: _____ **Phone:**

_____

**** This form is to be filed in the patient's medical record.**

Signature _____ **Date:** _____

Patient Name:_____ DOB:_____

Complaint: (Symptom, Onset, Progression)

_____

_____

_____

Please enter the approximate year of any of the illnesses you may have had and the treating physician or medical facility

Illness	Year	Dr/Hosp	Illness	Year	Dr/Hosp
Peptic Ulcers	_____	_____	Thyroid Problems	_____	_____
Diverticulosis	_____	_____	Endocrine Disorder	_____	_____
Crohn's	_____	_____	Cancer & type	_____	_____
Colitis	_____	_____	Anemia	_____	_____
Ulcerative Colitis	_____	_____	Bleeding Tendency	_____	_____
Hepatitis	_____	_____	Kidney Disease	_____	_____
Pancreatitis	_____	_____	Kidney Stone	_____	_____
Liver Disease	_____	_____	Prostate Trouble	_____	_____
Hemorrhoids	_____	_____	Stroke	_____	_____
High Blood Pressure	_____	_____	Arthritis	_____	_____
Heart Attack	_____	_____	Gout	_____	_____
Heart Murmur	_____	_____	Eye Disorder	_____	_____
Other Heart Conditions	_____	_____	Venereal Disease	_____	_____
Poor Circulation	_____	_____	Herpes	_____	_____
Bronchitis	_____	_____	Aids	_____	_____
Asthma	_____	_____	Diabetes	_____	_____
Pneumonia	_____	_____	Other	_____	_____
tuberculosis	_____	_____			

Please list approximate year of any surgery you may have had

Appendectomy_____ Colectomy_____ Hysterectomy(part/comp)_____

Gallbladder_____ Stomach Surgery_____ Other surgeries_____

Please list all medication you are now taking, including birth control pills and those you buy without a doctor's prescription (i.e. aspirin, cold tablets, etc.) List name, dosage, times per day.

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Please list any drug allergies.

1._____ 3._____ 5._____

2._____ 4._____ 6._____

Please give the following family history:

Patient Name_____ DOB_____

Relative:	Age if Living	Age of Death	Liver Disease	Peptic Disease	Gallbladder	Irritable Bowel	Hypertension	Heart Disease	Stroke	Diabetes	Cancer & Type	Blood Disease	Lung Disease	Tuberculosis	Kidney Disease	Mental Problems	Colon Polyps	Liver Disease, Cirrhosis	cause of death/comment
Father																			
Mother																			
Brother																			
Brother																			
Sister																			
Sister																			
Spouse																			
Child																			
Child																			

Please give a brief description of your job and daily activities (if retired, please state former occupation):

_____

_____

Have you had a recent tick, flea, mite, or any other pest or animal bite or scratch? If so, please describe:

_____

Have you traveled out of country in the past two years? If so, please indicate where:

_____

What are your hobbies? _____

Do you exercise? _____

How much coffee or tea do you usually drink? _____cups per day

Have you ever used "street drugs"? _____ If so, please describe below:

_____

Patient Name_____DOB_____

INSTRUCTION: Please check "yes" or "no".

Yes☐ No☐ **1)** Do you have any **difficulty swallowing** or do you get food lodged in your throat? (If you answered YES, please complete the following. If you answered NO, please go to number 2.)

Yes☐ No☐ a. Does **food lodge** in the back of your mouth?

Yes☐ No☐ b. Do liquids pass up your nose?

Yes☐ No☐ c. Do **solids (meat)** get stuck in your throat (esophagus) and requires vomiting to release?

Yes☐ No☐ d. Do you have frequent **heartburn?** (one episode nearly every day)

e. How long have your symptoms existed?_____

f. How frequently do your symptoms occur? (daily, weekly, monthly, other)

Yes☐ No☐ g. Do your symptoms occur equally with **liquids** as well as with solids?

Yes☐ No☐ **2)** Do you have any problems with **liver disease** or recent hepatitis? (If you answered YES, please complete the following. If you answered NO, please go to number 3.)

a. When were you first noted to have the problem?_____

Yes☐ No☐ b. Have you ever had **Hepatitis A**?

Yes☐ No☐ c. Have you ever had **Hepatitis B**?

Yes☐ No☐ d. Have you ever had **Hepatitis C**?

Yes☐ No☐ e. Have you ever had the hepatitis vaccine?

Yes☐ No☐ f. Have you ever received blood products? When_____

Yes☐ No☐ g. Do you eat **raw shellfish**?

Yes☐ No☐ h. In the past 5 years, have you had more than one **sexual partner**?

Yes☐ No☐ i. Have you had any problems with **gallbladder disease**?

Yes☐ No☐ j. Do you have any **family members** with liver disease?

Yes☐ No☐ **3)** Are you experiencing **rectal bleeding**? (If you answered YES, please complete the following. If you answered NO, please go to number 4.)

Yes☐ No☐ a. Is the blood **black** or your stools loose?

Yes☐ No☐ b. Is the blood **bright red** and surrounds normal stool?

c. How much blood with each movement? (Circle one) (less than a tablespoon, a tablespoon,1/2 cup, more than 1 cup)_____

Yes☐ No☐ d. Do you have **diverticulosis**?

Yes☐ No☐ e. Has the **caliber** (size) and shape of your stool changed?

Yes☐ No☐ f. Have you ever been found with **colon polyps** or **colon cancer**?

Yes☐ No☐ **4)** Are you experiencing **abdominal pain**? (If you answered YES, please complete the following. If you answered NO, please go to number 5.)

Yes☐ No☐ a. Is the pain located in your upper abdomen under your **breastbone**?

Yes☐ No☐ b. Do you have any radiation of your pain to your **back**?

c. Is your pain a dull, persistent pressure, or burning discomfort? (Circle one).

Yes□ No□ d. Are you experiencing a lot of **heartburn**?

Yes□ No□ e. Is your pain a **sharp pain** lasting for several hours and relieved only to return again either later that day or the next day?

Yes□ No□ f. Is your pain exaggerated **(worse) after eating**?

Yes□ No□ g. Are you experiencing nausea with **vomiting**?

h. Are there factors which relieve your pain? circle write (antacids, medication ,etc.)

Yes□ No□ i. Is the pain located in your **lower abdomen**?

Yes□ No□ j. Is your pain worse **prior to defecation** and or relieved after a bowel movement?

Yes□ No□ **5)** Are you experiencing any changes in your **bowel habits**? (constipation or diarrhea). (If you answered YES, please complete the following. If you answered NO, please go to number 6.)

Yes□ No□ a. Are you having loose, **watery stools**?

b. How long have you had diarrhea?_____.

c. How many diarrhea movements per day do you have?_____

Yes□ No□ d. Is the **amount** of diarrhea related to how much you eat? (i.e., **fasting** will stop your diarrhea)

Yes□ No□ e. Is your diarrhea stool more **foul** smelling than before?

Yes□ No□ f. Does your diarrhea stool **always float** in the toilet and is hard to flush?

Yes□ No□ g. Have you noticed a frequent film of **oil** in the toilet after movements?

Yes□ No□ h. Is your diarrhea **intermittent** with period of normal stools?

Yes□ No□ i. Does your diarrhea **alternate** with constipation? (i.e., hard stools followed with diarrhea).

Yes□ No□ j. Are you having difficulty with **hard stools**?

Yes□ No□ k. Are your stools small and **pellet-like**?

Yes□ No□ l. Do you drink plenty of **water** (i.e., greater than 6 glasses per day.)

m. Are you using **fiber supplements**? Name_____

n. Do you use **laxatives** like Ex-Lax? Name_____

Yes□ No□ **6)** Have you ever had an UGI series? (Date_____)

Yes□ No□ **7)** Have you ever had a gastroscopy? (Date_____)

Yes□ No□ **8)** Have you ever had a barium enema? (Date_____)

Yes□ No□ **9)** Have you ever had a colonoscopy? (Date_____)

Patient Name_____DOB_____

Yes□ No□ **10)** Have you ever had an ultrasound or CT scan? (Date_____)

wt. loss fever	Yes□	No□	11)	Has your weight changed in the past 3 months?
chills, sweats	Yes□	No□	12)	Are you having a fever?
adenopathy	Yes□	No□	13)	Are you having night sweats or chills?
fatigue	Yes□	No□	14)	Do you have any enlarged glands?
headaches	Yes□	No□	15)	Do you feel tired or weak?
blurry vision	Yes□	No□	16)	Do you have frequent headaches?
	Yes□	No□	17)	Do you have trouble with your eyes? (Blurriness, spots, irritation)
glasses	Yes□	No□	18)	Do you wear **glasses or contacts**?
tinnitus	Yes□	No□	19)	Do you have **trouble with your ears**? (Deafness, ringing, discharge)
motion sickness	Yes□	No□	20)	Do you have any **motion sickness** or dizziness?
epistaxis	Yes□	No□	21)	Do you have **nose bleeds**?
hoarseness	Yes□	No□	22)	Are you experiencing **hoarseness**?
colds URI	Yes□	No□	23)	Do you have head **colds** or runny nose?
oral prob.	Yes□	No□	24)	Do you have any **allergies**? _____
Dentures	Yes□	No□	25)	Do you have any problems with your teeth, gums, mouth or tongue?
Olfactory	Yes□	No□	26)	Do you wear **dentures**?
	Yes□	No□	27)	Have you noticed any change in **smell/taste?**
HTN	Yes□	No□	28)	Do you have **high blood pressure**?
chest pain leg	Yes□	No□	29)	While exercising, do you have **chest pain**?
cramps	Yes□	No□	30)	Do you get **leg or thigh cramps** while walking?
palpitations	Yes□	No□	31)	Do you feel your **heart racing** too fast?
irreg. HB	Yes□	No□	32)	Does your heart beat too slow or irregular?
syncope	Yes□	No□	33)	Have you felt **light-headed** or passed out?
edema	Yes□	No□	34)	Do you have **swelling** of your ankles?
murmurs	Yes□	No□	35)	Do you have any **heart murmurs**?
venous insuf.	Yes□	No□	36)	Do you have **varicose veins** or leg vein clots?
Reynaud's	Yes□	No□	37)	Any blue color to fingers or toes?
PND	Yes□	No□	38)	Do you use two pillows to rest better?
	Yes□	No□	39)	Do you sit up at night to breathe easier?
	Yes□	No□	40)	Do you have difficulty breathing with **light activities**?
cough	Yes□	No□	41)	Do you have **early morning** cough?
	Yes□	No□	42)	Do you have a cough that **persists** all day?
	Yes□	No□	43)	Are you coughing up **sputum**?
	Yes□	No□	44)	Are you coughing up **blood**?
bronchitis	Yes□	No□	45)	Do you have wheezing or bronchitis episodes?
	Yes□	No□	46)	Have you ever had an EKG? (Date_____)
	Yes□	No□	47)	Have you ever had a chest x-ray? (Date_____)
	Yes□	No□	48)	Have you ever had a TB skin test? (Date_____)

Patient Name_____ DOB_____

Dysuria	Yes□	No□	49)	Have you had a recent bladder or **kidney problem**?
Frequency	Yes□	No□	50)	Are you having **burning** with urination?
Nocturia	Yes□	No□	51)	Are you urinating more **frequently**?
Hesitancy	Yes□	No□	52)	Do you get up at **night** to urinate?
Hematuria	Yes□	No□	53)	Is it hard to start your urine flow?
	Yes□	No□	54)	Has your urine been **bloody** or dark-colored?
	Yes□	No□	55)	Do you leak urine when laughing or coughing?
UTI	Yes□	No□	56)	Have you been treated recently for **bladder infection**?
Stones	Yes□	No□	57)	Have you had kidney **stones**?
	Yes□	No□	58)	Have you had a recent urinalysis? (Date_____)

FOR MALES ONLY (FEMALES GO TO #61)

	Yes□	No□	59)	Have you had recent **prostate trouble**?
	Yes□	No□	60)	Any sore or swelling of penis or testicles?

FOR FEMALES ONLY (MALES GO TO # 70)

	Yes□	No□	61)	What was your age at start of menstruation?____
	Yes□	No□	62)	What was the date of last menstruation?_____
	Yes□	No□	63)	Are your cycles abnormal or **irregular**?
	Yes□	No□	64)	Is your menstruation **heavy**?
	Yes□	No□	65)	Do you have any problems with discharge or **infection**?
	Yes□	No□	66)	Do you take **birth control pills**?
	Yes□	No□	67)	Do you take **hormones**?
	Yes□	No□	68)	Do you have any breast **lumps**, discharges, pain, changes?
	Yes□	No□	69)	Have you had a **mammogram**? (Date_____)
Temp. tolerance	Yes□	No□	70)	Do you always feel **warmer** than those around?
	Yes□	No□	71)	Do you always feel **cooler** than those around?
	Yes□	No□	72)	Do you have **hot flashes**?
Thyroid disease	Yes□	No□	73)	Have you ever had a **goiter**?
	Yes□	No□	74)	Have you had **thyroid problems**?
	Yes□	No□	75)	Do you have excessive **thirst**?
Anemia bleeding bruising blood transfusion	Yes□	No□	76)	Have you ever been **anemic**?
	Yes□	No□	77)	Do you have any **bleeding problems** with deep cuts or after surgery?
	Yes□	No□	78)	Do you have any problems with **bruising**?
	Yes□	No□	79)	Have you received any **blood transfusions**?

Patient Name_____DOB_____

rheum. disease back injury joint skin disease moles	Yes□	No□	80)	Do you have any **deformities** of back, arms, legs?
	Yes□	No□	81)	Have you had any **back injuries**?
	Yes□	No□	82)	Do you have **joint pain**, swelling, or stiffness?
	Yes□	No□	83)	Do you have any skin or **rash** problems?
	Yes□	No□	84)	Do you have any **moles** that have changed in color or size?
	Yes□	No□	85)	Do you get **cold sores** or fever blisters?
CNS	Yes□	No□	86)	Have you had a **stroke**?
	Yes□	No□	87)	Does any part of your body get **numb**?
	Yes□	No□	88)	Have you ever had **seizures**?
	Yes□	No□	89)	Do you have a problem with **coordination**?
mental	Yes□	No□	90)	Do you have unusual **memory loss**?
	Yes□	No□	91)	Do you feel **nervous** or anxious?
	Yes□	No□	92)	Do you feel **depressed** or sad?
	Yes□	No□	93)	Have you had any changes in **sleep pattern**?

TOBACCO UTILIZATION

□NEVER USED		
□FORMER USER	□<1 MONTH □1-3 MONTHS □3-6 MONTHS □6-12 MONTHS □1-5 YEARS □5-10 YEARS □>10YRS	
□CURRENT USER	□DAILY □SPORADICALLY	□READY TO QUIT □ NOT QUITTING
	FIRST SMOKE IS _____ MINUTES UPON AWAKENING.	
	SMOKES PER DAY: □<5 □6-10 □11-20 □21-30 □≥31	

ALCOHOL CONSUMPTION

□NONE	□1-2 DAYS PER MONTH
□1-2 DAYS PER WEEK	□MOST DAYS
AVERAGE DAILY AMOUNT?	
□ 1-2 DRINKS	□3-4 DRINKS □5 -6 DRINKS □≥6 DRINKS



ALEXANDRIA GASTROENTEROLOGY ASSOCIATES

Joseph D. Hollier, M.D. ● Kimberly Sills, APRN, FNP-BC

NO-SHOW AND CANCELLATION POLICY

Due to a large increase of last-minute cancellations and no shows for office visits and endoscopy procedures, Alexandria Gastroenterology and Associates will instate a no-show or last-minute cancellation fee **Effective January 1, 2023.**

CANCELLATIONS AND NO SHOWS FOR SCHEDULED OFFICE VISITS:

Cancellation of any office visit requires a minimum of 48 hours notice. If any appointment is not cancelled 48 hours prior to your appointment, there will be a $25.00 cancellation fee which must be paid in full prior to rescheduling your next appointment.

If you do not show up for your appointment, there will be a $25.00 no-show fee that must be paid in full prior to rescheduling your next appointment.

CANCELLATIONS AND NO SHOWS FOR ENDOSCOPY PROCEDURES:

Cancellation of a colonoscopy, EGD or other scheduled endoscopy procedure requires a minimum of 72 hours notice. If any scheduled endoscopy procedure is not cancelled in at least 72 hours prior to the procedure, there will be a $75.00 cancellation fee that must be paid prior to scheduling your next office visit OR rescheduling an endoscopy procedure.

If you do not show up for your colonoscopy, EGD or other scheduled endoscopy procedure, there will be a $75.00 no-show fee that must be paid prior to scheduling your next office visit OR rescheduling an endoscopy procedure.

*****NO SHOW AND CANCELLATIONS FEES ARE THE RESPONSIBILITY OF THE PATIENT. INSURANCE DOES NOT COVER NO SHOW AND CANCELLATION FEES AND WILL NOT BE FILED*****

REPEAT OFFENDERS:

Any office visit or endoscopy procedure that is consistently rescheduled or no showed could result in being discharged from our clinic

Patient Printed Name: _____ **Date:** _____

Patient Signature: _____

1587 North Bolton Avenue, Suite 1100 ● Alexandria, LA 71303 ● Ph. 318-473-8188 ● Fax 318-473-8682