New Patient Registration

MAB
MEDICAL ASSOCIATES OF BREVARD

Patient Information

Patient Name

_____

First MI Last

DOB ___/___/___ SS# _____

Marital Status_____ ○ MALE ○ FEMALE

Address _____

_____

Home Phone _____ Cell _____

Work Phone _____

Employer _____

Occupation _____

Name of Spouse _____

Address: _____

_____

○ Check if same as patient's address

Race

○ American Indian or Alaska Native ○ Asian
○ Native Hawaiian ○ Black or African American ○ White
○ Other Pacific Islander ○ Prefer not to answer

Ethnicity

○ Hispanic/Latino ○ Non-Hispanic/Latino
○ Prefer not to answer

Preferred Language

○ English ○ Spanish ○ French ○ Indian (includes Hindu & Tamil) ○ Other _____

Preferred Pharmacy _____

Location _____

Family Doctor _____

Phone _____

Insurance Information

Primary Insurance Co _____

Policy #: _____

Policy holder information, if not same as patient:

Name _____

DOB ___/___/___ SS# _____

Secondary Insurance Co _____

Policy #: _____

Policy holder information, if not same as patient:

Name _____

DOB ___/___/___ SS# _____

Complete below if patient is a minor

Father's Name (or Guardian) _____

DOB ___/___/___ SS# _____

Home Phone _____ Cell _____

Work Phone _____

Address: _____

_____

○ Check if same as patient's address

Employer _____

Mother's Name (or Guardian) _____

DOB ___/___/___ SS# _____

Home Phone _____ Cell _____

Work Phone _____

Address: _____

_____

○ Check if same as patient's address

Employer _____

MAB
MEDICAL ASSOCIATES OF BREVARD

New Patient Registration

HIPAA Release

Patient Name

First MI Last

Do you have a Living Will? ◯ Yes ◯ No
Do you have an Advance Directive? ◯ Yes ◯ No
If you answered yes to either, please provide us a copy.

Emergency Contact:

Name Relationship

Phone #

I authorize Medical Associates of Brevard LLC to discuss my healthcare information with the below:

Name Relationship

Phone #

Name Relationship

Phone #

Preferred appointment reminder notification:
◯ Home Phone ◯ Cell ◯ Cell Text ◯ Work phone
◯ Mail ◯ E-Mail ◯ None
◯ With the person(s) authorized above

Preferred medical information notification:
I authorize Medical Associates of Brevard LLC to leave a detailed message which may contain personal health information via:
◯ Home Phone ◯ Cell ◯ Cell Text ◯ Work phone
◯ Mail ◯ E-Mail ◯ None
◯ With the person(s) authorized above

Note that authorization to contact via phone includes authorization for us to leave a message on your voicemail or answering machine.

Your HIPAA contact information will be recorded as you have indicated here. You will be asked to electronically sign to confirm this information.

MAB GASTROENTEROLOGY
JOHN C. TURSE, M.D.
ADWAIT JATHAL, M.D.
321-952-0700

Today's Date: _____

Patient: _____ DOB: _____

Credit Card Authorization Form

I authorize MAB GI to charge my credit card for the portion of my health care costs as determined by my insurance company. This will be charged upon MAB-GI's receipt of my Explanation of Benefits (EOB).

Charge to: **Visa** **Mastercard** **American Express** **Discover** **Debit Card**

Name as it appears on card: _____

Credit card Number: _____ _____ _____ _____

Exp. Date: _____ Sec Code: _____

Billing Address of Cardholder: _____

City: _____ St: _____ Zip: _____

Signature of cardholder: _____

OFFICE USE ONLY

Procedure to be scheduled: ____Colonoscopy ____EGD ____ Other _____

Date of Procedure: _____

The estimated cost of the procedure(s) is $_____

Method of payment: _____ Cash _____ Check _____ Credit Card

Amount paid today $_____

MAB
MEDICAL ASSOCIATES
— OF BREVARD —

Health History Form

NAME: _____ DATE: _____

BIRTHDATE: _____ AGE: _____ REFERRED BY: _____

HEIGHT: _____ WEIGHT: _____ PRIMARY CARE DOCTOR: _____

PHARMACY (name, location, phone/fax number): _____

ALLERGIES:

☐ NONE	☐ Codeine	☐ Iodine dye	☐ Morphine	☐ Propofol	☐ Surgical tape
☐ Aspirin	☐ Demerol	☐ Latex	☐ Penicillin	☐ Sulfa	☐ Versed

Other: _____

Any prior difficulties with sedation or anesthesia (nausea/vomiting, high tolerance, other)? ☐ Yes ☐ No

REASON FOR YOUR VISIT TO THE OFFICE

☐ Heartburn	☐ Difficulty swallowing	☐ Painful swallowing	☐ Regurgitation
☐ Excessive belching	☐ Chest pain	☐ Nausea	☐ Vomiting
☐ Upper abdominal pain	☐ Lower abdominal pain	☐ Bloating	☐ Gas/flatulence
☐ Diarrhea	☐ Constipation	☐ Narrowed stools	☐ Rectal pain/itch
☐ Rectal bleeding	☐ Black stools	☐ Hemoccult + stools	☐ Anemia
☐ Decreased appetite	☐ Weight loss	☐ Abnormal liver tests	☐ Jaundice
☐ Screening colonoscopy	☐ Personal history of colon polyps/cancer	☐ Family history of colon polyps/cancer	☐ Abnormal ultrasound or CAT scan

Date of last Colonoscopy/Endoscopy:

_____

Have you had any of the following done to evaluate for the cause of your symptoms?

☐ Laboratory tests or blood work

☐ Radiology imaging (x-rays, ultrasounds, CAT scans, MRIs, barium studies)

☐ Emergency room visits

** *If possible, we would greatly appreciate it if you could please bring any of these relevant records with you or have them faxed to our office in advance of your visit 321-592-4444.*

What medications, supplements, or dietary interventions have you tried to treat your symptoms with (non-prescription and prescription)?

_____

_____

PAST MEDICAL ILLNESSES

Gastrointestinal

- ☐ Heartburn/GERD
- ☐ Hiatal hernia
- ☐ Gastritis
- ☐ H. pylori
- ☐ Ulcer
- ☐ Celiac disease
- ☐ Bowel obstruction
- ☐ Gallstones
- ☐ Pancreatitis
- ☐ Irritable bowel (IBS)
- ☐ Lactose intolerance
- ☐ Diverticulosis
- ☐ Diverticulitis
- ☐ Ulcerative colitis
- ☐ Crohn's disease
- ☐ Colon polyp
- ☐ Colon cancer
- ☐ Hemorrhoids
- ☐ Anal fissure
- ☐ Anal fistula
- ☐ Stool incontinence
- ☐ Abnormal liver tests
- ☐ Fatty liver
- ☐ Hepatitis
- ☐ Cirrhosis

Cardiovascular

- ☐ High blood pressure
- ☐ Atrial fibrillation
- ☐ High cholesterol
- ☐ Rhythm disorder
- ☐ Heart attack
- ☐ Heart murmur
- ☐ Congestive heart failure

Pulmonary

- ☐ Sleep apnea
- ☐ Pulmonary embolism
- ☐ Asthma
- ☐ Sarcoidosis
- ☐ Emphysema
- ☐ Lung cancer
- ☐ Pneumonia
- ☐ Pleurisy

Neuropsychiatric

- ☐ Stroke or TIA
- ☐ Migraines
- ☐ Chronic headaches
- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar disorder
- ☐ Eating disorder
- ☐ Parkinson's disease
- ☐ Multiple Sclerosis
- ☐ Seizures
- ☐ Myasthenia gravis
- ☐ Dementia

Endocrine

- ☐ Diabetes
- ☐ Hypothyroidism
- ☐ Thyroid nodule
- ☐ Hyperthyroidism
- ☐ Goiter
- ☐ Pituitary problem
- ☐ Thyroid cancer
- ☐ Adrenal problem

Genitourinary

- ☐ Kidney disease
- ☐ Urinary tract infections
- ☐ Ovarian cyst(s)
- ☐ Ovarian cancer
- ☐ Kidney stones
- ☐ Bladder incontinence
- ☐ Uterine fibroids
- ☐ Uterine cancer
- ☐ Kidney tumors/cysts
- ☐ Prostate hypertrophy
- ☐ Abnormal pap smears
- ☐ Cervical cancer
- ☐ Bladder cancer
- ☐ Prostate cancer
- ☐ Cone biopsy/LEEP
- ☐ Endometriosis

Breast

- ☐ Fibrocystic breast changes
- ☐ Benign breast biopsy
- ☐ Breast cancer
- ☐ Chemo/radiation/surgery

Musculoskeletal

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

Eyes, Ears, Nose, and Throat

- ☐ Glaucoma
- ☐ Allergic rhinitis
- ☐ Sinusitis
- ☐ Oral thrush

Dermatologic

- ☐ Eczema
- ☐ Raynaud's syndrome
- ☐ Psoriasis
- ☐ Basal cell skin cancer
- ☐ Vitiligo
- ☐ Squamous cell cancer
- ☐ Alopecia
- ☐ Melanoma

Hematologic

- ☐ Anemia
- ☐ Blood transfusion
- ☐ Blood clot
- ☐ Hemochromatosis

Other: _____

Additional health history:

☐ Any other malignant tumors/cancers not previously mentioned: _____

☐ Any communicable disease, such as hepatitis, HIV, or sexually transmitted disease? _____

☐ Any other hospitalizations or medical conditions not previously mentioned: _____

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	☐ Vasectomy
☐ Prostate surgery	☐ Back surgery	☐ Lumpectomy	☐ Mastectomy
☐ Stent/angioplasty	☐ Heart bypass surgery	☐ Heart valve surgery	☐ Pacemaker
☐ Defibrillator	☐ Carotid surgery	☐ Vascular surgery	☐ Vein stripping

☐ Any other surgeries not previously mentioned: _____

MEDICATIONS

Please include all prescription and non-prescription medications (especially anti-inflammatories like Advil, Motrin, and Aspirin), as well as all supplements.

Medication Name	Dose and Frequency

SOCIAL HISTORY

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed Children (ages): _____

Occupation: _____

Do you use tobacco currently? ☐ Yes ☐ No

Did you ever use tobacco products? ☐ Yes ☐ No

When did you quit? _____

Number of packs per day? _____

How many years? _____

Do you drink alcohol? ☐ Yes ☐ No

Number of cups per day of caffeinated beverages? _____

How many glasses do you drink per day? _____

How many glasses do you drink per week? _____

Have you ever had a problem with alcohol or drug use? _____

FAMILY HISTORY

☐ Colon polyps	☐ Helicobacter pylori	☐ Crohn's disease	☐ Hepatitis B
☐ Colon cancer	☐ Stomach cancer	☐ Ulcerative colitis	☐ Hepatitis C
☐ Uterine cancer	☐ Ovarian cancer	☐ Celiac disease	☐ Hemochromatosis

If yes, list family members (i.e. mother, grandmother, sister, aunt) and age at diagnosis if polyps or cancers:

_____

REVIEW OF SYSTEMS

General

☐ Fatigue ☐ Weakness ☐ Fever ☐ Night sweats

Cardiovascular

☐ Chest pain ☐ Palpitations ☐ Shortness of breath with exertion

☐ Ankle swelling/edema ☐ Varicose veins

Respiratory

☐ Cough ☐ Coughing blood ☐ Shortness of breath ☐ Wheezing

Neurologic

☐ Headaches ☐ Dizziness ☐ Localized numbness ☐ Speech difficulty

☐ Memory loss

Endocrine

☐ Cold intolerance ☐ Heat intolerance ☐ Excessive thirst ☐ Excessive hunger

☐ Dry skin ☐ Abnormal skin pigment ☐ Abnormal body hair ☐ Brittle hair

Genitourinary

☐ Blood in urine ☐ Burning urination ☐ Urinary incontinence ☐ Frequent urination

☐ Frequent urination at night

Males: ☐ Slow urinary stream ☐ Difficulty initiating urination ☐ Penile discharge

Females: ☐ Abnormal periods ☐ Menopause ☐ Vaginal discharge

Breast

☐ Lump(s) ☐ Pain ☐ Nipple discharge ☐ Enlargement (males)

Bones/Joints/Muscles

☐ Pain ☐ Swelling ☐ Stiffness

Oropharyngeal

☐ Mouth sores ☐ Tongue sores ☐ Tooth/gum problems

Skin

☐ Itching ☐ Rash ☐ Scaling

Hematology

☐ Swollen jaw ☐ Bruising ☐ Bleeding problems

_____

Patient's Signature **Date**