Kalamazoo Gastroenterology Hepatology Digestive Health Center

Last Name	First Name	Middle Name

Birth Sex	Current Gender	Date of Birth

What gender do you Identify with?

- ☐ Female
- ☐ Female-to-male/Transgender Male/Trans Man
- ☐ Genderqueer, neither exclusively male nor female
- ☐ Male
- ☐ Male-to-female/Transgender Female/Trans Woman
- ☐ Choose not to disclose

Medication(s) & Allergies - Please bring a complete list to your appointment. List of medication should include: name, dosage and directions

Review of Systems: Indicate if you are having CURRENT problems or symptoms in any of the following areas.

Constitutional
- ☐ Chills
- ☐ Fever
- ☐ Fatigue
- ☐ Weight loss

Other:

HEENT
- ☐ Double vision
- ☐ Ear infections
- ☐ Eye pain
- ☐ Nasal congestion
- ☐ Sinus infection
- ☐ Sore throat

Other:

Respiratory
- ☐ Shortness of breath
- ☐ Frequent cough
- ☐ Pain with breathing
- ☐ Wheezing

Other:

Cardiovascular
- ☐ Chest pain
- ☐ Leg edema/swelling
- ☐ Palpitations

Other:

Gastrointestinal
- ☐ Abdominal pain
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult swallowing
- ☐ Heartburn
- ☐ Vomiting blood
- ☐ Blood in stool
- ☐ Loss of appetite
- ☐ Black tarry stool
- ☐ Nausea
- ☐ Reflux
- ☐ Vomiting

Other:

Genitourinary
- ☐ Trouble urinating
- ☐ Blood in urine
- ☐ Urinary frequency
- ☐ Urinary incontinence
- ☐ Urinary retention

Other:

Male Reproductive
- ☐ Penile discharge
- ☐ Sexual dysfunction

Other:

Metabolic/Endocrine
- ☐ Cold intolerance
- ☐ Excessive thirst
- ☐ Heat intolerance

Other:

Neurological
- ☐ Dizziness
- ☐ Headache
- ☐ Numbness
- ☐ Tremors
- ☐ Vertigo - room spinning

Other:

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Increased stress

Other:

Integumentary
- ☐ Contact allergy
- ☐ Hives
- ☐ Itching
- ☐ Rash

Other:

Musculoskeletal
- ☐ Back pain
- ☐ Muscle pain
- ☐ Lack of energy
- ☐ Joint pain

Other:

Hematologic/Lymphatic
- ☐ Easy bleeding
- ☐ Easy bruising
- ☐ Enlarged lymph nodes

Other:

Immunologic
- ☐ Asthma
- ☐ Chemicals in work place
- ☐ Food allergies
- ☐ Immunosuppression
- ☐ Seasonal allergies

Other:

Female Reproductive
- ☐ Breast lumps
- ☐ Menstrual problems
- ☐ Vaginal discharge
- ☐ Other:

Past Medical History: Please check box if you have a history of any of the following.

- ☐ Alcoholism
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood transfusion
- ☐ ***C-Diff***
- ☐ Celiac disease
- ☐ Cholelithiasis
- ☐ Chronic renal failure
- ☐ Cirrhosis
- ☐ Colon Cancer
- ☐ Colon polyps
- ☐ Congestive heart failure
- ☐ COPD
- ☐ Coronary artery disease
- ☐ Crohn's disease
- ☐ Cerebrovascular accident
- ☐ Diabetes mellitus
- ☐ Diverticular disease
- ☐ Exposure to hepatitis
- ☐ GERD
- ☐ Gout
- ☐ Hemochromatosis - hereditary
- ☐ Hepatitis
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Irritable bowel syndrome
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Liver cancer
- ☐ Liver disease
- ☐ Migraine headaches
- ☐ ***MRSA***
- ☐ Obesity
- ☐ Other:
- ☐ Pancreatitis
- ☐ Parkinson's disease
- ☐ Peptic ulcer disease
- ☐ Prostate cancer
- ☐ Prostate hyperplasia, benign
- ☐ Seizure disorder
- ☐ Thyroid disease
- ☐ Ulcerative colitis
- ☐ Varices - esophageal
- ☐ Varices - gastric

Past Surgical History: Please tell us the year if you have had any of the following.

	Year		Year		Year		Year
Angioplasty:		Colon resection, partial:		Implantable cardioverter defibrillator:		Prostate surgery:	
Angio w/stent:		Colostomy:		Knee replacement:		Vasectomy:	
Appendectomy:		Gallbladder surgery:		Liver biopsy:		Bilateral tubal ligation:	
Back surgery:		Gastric bypass:		Small bowel resection:		Cesarean section:	
Cardiac bypass surgery:		Hernia repair:		Thyroidectomy:		Hysterectomy:	
Carpal tunnel release:		Hip replacement:		Prostate biopsy:		Mastectomy:	

Other:

Family History: Please indicate if anyone has had the following conditions.

Circle accordingly: M = Mother, F = Father, S = Sister, B = Brother, C = Child(ren)

Alcoholism	M	F	S	B	C	Hyperlipidemia	M	F	S	B	C
Blood disorders	M	F	S	B	C	Hypertension	M	F	S	B	C
Coronary artery disease	M	F	S	B	C	Irritable bowel syndrome	M	F	S	B	C
Cancer	M	F	S	B	C	Liver disease	M	F	S	B	C
Type:						Migraine headaches	M	F	S	B	C
Celiac disease	M	F	S	B	C	Obesity	M	F	S	B	C
Colitis	M	F	S	B	C	Osteoporosis	M	F	S	B	C
Colon cancer	M	F	S	B	C	Renal disease	M	F	S	B	C
Colon polyps	M	F	S	B	C	Rheumatoid arthritis	M	F	S	B	C
Crohn's disease	M	F	S	B	C						

Date of last influenza vaccine: Date of last shingles vaccine:

Date of last pneumonia vaccine:

Preferred Pharmacy:

Social History

Tobacco Use:

- ☐ Former Age Started: Age Stopped:
- ☐ Never
- ☐ Current Age Started:

Type: ☐ Chew ☐ Pipe ☐ Cigar ☐ Snuff ☐ Cigarettes

How much per day?

Vaping Use:

- ☐ Not a current user
- ☐ Current

Age Started: Age Stopped:

Nicotine used with vaping Y N

Device Type:

Current Strength:

Do you consume any alcohol? Yes No

- ☐ Beer ☐ Methanol ☐ Whiskey
- ☐ Gin ☐ Rum ☐ Vodka
- ☐ Liquor ☐ Scotch ☐ Wine

How much per day?

How Often?

Last Drink?

Do you consume any caffeine? Yes No

- ☐ Chocolate ☐ Soda
- ☐ Coffee ☐ Tablet
- ☐ Energy Drink ☐ Tea

How much per day?

Patient Signature Date

Kalamazoo Gastroenterology Hepatology and Digestive Health Center

A DIVISION OF PARAGON HEALTH, P.C.

Specialists in Digestive Diseases

BRIJ M. DEWAN, M.D. AIJAZ H. TURK, M.D. KEVIN L. BEYER, D.O. TARUN K. SHARMA, M.D.

PATIENT INFORMATION

Patient's Name: _____
First Middle Last

Today's Date	Patient's Birthdate	Patient's Sex	Patient's SS#

Patient's Address_____ Apt/Lot #_____

City/State/Zip Code _____

Home Phone_____Cell_____

E-mail_____

Patient's Employer Name_____

Address _____

_____

Phone_____Ext_____

Financially Responsible Party (Minors Only)

Name_____

Address _____Apt/Lot #_____

_____

Phone_____

Responsible Party SS#_____

Referring Doctor or Primary Care Doctor

Name _____

Address _____

_____

Phone_____

Type of Doctor_____

Emergency Contact_____ Phone_____ Relation_____

INSURANCE INFORMATION

PRIMARY INSURANCE (TO BE BILLED FIRST)	**SECONDARY INSURANCE**
Contract # Group #	Contract # Group #
Policy Holder Name Relation	Policy Holder Name Relation
Policy Holder DOB Policy Holder SS#	Policy Holder DOB Policy Holder SS#
Policy Holder Employer	Policy Holder Employer

I hereby authorize Paragon Health, P.C., DBA Kalamazoo Gastroenterology Hepatology and/or Digestive Health Center to examine and treat my child, or me and to perform such diagnostic tests and/or x-rays as may be necessary for the duration of treatment for this injury or illness. I hereby authorize the release of any medical information necessary to process my Medicare and/or insurance claims and for any benefits payable under my policy be paid directly to Kalamazoo Gastroenterology Hepatology or Digestive Health Center. I understand that I am responsible for payment of any charges incurred and I accept this responsibility regardless of any reimbursement or coverage. If my account requires collection activities I agree to pay all reasonable fees incured.

Signature of Patient: _____ Date: _____

Kalamazoo Gastroenterology Hepatology Digestive Health Center

CONTACT AUTHORIZATION

The following people are authorized to speak to your office on my behalf:

_____, _____, _____,

_____, _____, _____

☐ **Do not release any information to anyone except the patient.**

You are authorized to leave a message on my answering machine. ☐ Yes ☐ No

You are authorized to call me at work and/or leave a message. ☐ Yes ☐ No

_____ _____

Patient or personal representative signature Date

To be completed at first visit.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below I acknowledge that the Notice of Privacy Practices was made available to me.

_____ _____

Name of Patient (please print) Signature of patient or personal representative

_____ _____

Date If signed by personal representative, relationship to patient.

Office Use Only:

Our practice will make a good faith effort to obtain a written acknowledgement of receipt of the Notice provided to the individual. If written acknowledgement is not obtained, our practice must document its good faith efforts to obtain such acknowledgement and record the reason why the acknowledgement was not obtained.

☐ REFUSED TO SIGN ☐ PHYSICALLY UNABLE TO SIGN

Employee Signature:_____ Division: _____ Date: _____

Digestive Health Center
3770 Capital Ave, S.W., Suite B
Battle Creek, MI 49015
269-441-1776
Fax 269-441-1774

Medical Specialties Building
1535 Gull Road, Suite 105
Kalamazoo, MI 49048-1639
269-385-9900
Fax 269-385-2140

Westside Medical Center
6565 West Main, Suite C
Kalamazoo, MI 49009
269-385-9900
Fax 269-385-2140

PATIENT FINANCIAL POLICY

Thank you for choosing Kalamazoo Gastroenterology Hepatology & Digestive Health Center (KGH/DHC), a division of Paragon Health, P.C., as your health partner. We strive to provide the highest quality care at the most affordable prices.

Our Payment-In-Full Policies save costly billing expenses. Our goal is to educate you about your health *and* your insurance policy. Knowing your benefits and financial responsibility helps you make informed medical decisions that keep you both medically and financially healthy. We ask that you familiarize yourself with our financial policies and your insurance policy so that we can work together.

If at any time you have questions regarding any service or fee, please discuss them with us promptly. We will make every effort to avoid misunderstandings and to rectify any errors. Please ask for a billing specialist at (269) 385-9900.

What insurance companies do you participate with?
We participate with most major health insurance companies.

How much do I pay?
Your insurance company determines how much you pay. If you do not have insurance or we do not participate with your insurance, we require a deposit for our estimated charges when scheduling an office visit/procedure.

When and how can I pay?
We accept cash, check or credit card (Visa, MasterCard or Discover).

Office Visits: Our staff verifies your insurance coverage before you arrive, this allows us to inform you of what your responsibility is. We collect all copays, coinsurance, deductibles and outstanding balances when you check in at the office.

Procedures: If a provider orders a procedure, we verify your coverage and obtained any prior authorizations needed. Please note that our physician's charge is separate from the facility charge. You will get a separate bill from the facility, anesthesiologist, radiologist and pathologist as necessary.

What if I miss appointments?
We require 24 hours (1 business day) notice to cancel or reschedule office visits or infusions and 72 hours (3 business days) for procedures. Failure to give sufficient cancellation notice will result in a cancellation fee ($25 office visit/$50 infusion/$75 procedure). Late arrival for an appointment may require you to reschedule. Continued failed or late arrivals will result in discharge from our practice.

Do you have charges for other services?
We apply a modest charge for the items described below.

Statement Fee - $15 if payment due is not made at the time of service.
Non-sufficient Funds - $25 for each returned check.
Form Completion - $25 (due in advance) for each form. Examples: Disability, FMLA, etc.
Medical Records Release – We transfer medical records at no charge to other physicians.
-A charge based on the MI Medical Records Access Act (Public Act 47) will be applied for all requests for a patient's personal use.

Insurance Billing Process

Your health insurance policy is an agreement between you and your insurance carrier. To avoid any confusion, we strongly suggest that patients contact their insurance company to make certain that our services are covered and where labs, x-rays, procedures and hospitalizations should be performed.

Due to Medicare/Medicaid policy standards, you do not need to contact Medicare/Medicaid regarding what services are covered.

We will bill your insurance company for covered services based on federal coding guidelines and contracts with participating health plans. Hence, the patient is responsible to us and the insurance company is responsible to the patient.

What if I do not honor these policies?

We will be sensitive to your financial circumstances within the framework of good business practices. An account with outstanding balances will be referred to a collection agency approximately 90 days from date of service. We may not be able to schedule you for services if you have a delinquent account balance. If your account is not brought current, we may regretfully have to ask you to seek care with another practice.

Acknowledgement of Financial Responsibility

I assign to KGH/DHC all insurance payments for medical services provided to me by KGH/DHC.

I accept full financial responsibility for the services rendered and all fees associated with those services. I also agree to pay in full at time of service. I understand that KGH/DHC reserves the right to change their policies and fees without notice.

_____ _____

Signature Date