GASTROINTESTINAL MEDICINE ASSOCIATES, INC.
www.GIMEDRI.com

THOMAS H. McGREEN, M.D. ■ ROBERT WOLFGANG, D.O. ■ MORRIS P. ELEVADO, M.D. ■ ROBERT J. BIERWIRTH, M.D. ■ COLIN M. WOODARD, D.O.
DEIRDRE E. SMITH, APRN, CNP ■ LAUREN M. GALLAGHER, APRN, CNP ■ KAREN SCHAFFRAN, APRN, CNP

DATE:_____

_____**has an appointment with**_____

on_____**at**_____**in the**_____**office**.

****** Please bring in a list of your current medications. ******

NEW PATIENTS

PLEASE FILL OUT THE ENCLOSED FORMS AND BRING IN WITH YOU AT THE TIME OF YOUR VISIT. PLEASE MAKE SURE YOU ALSO BRING IN YOUR INSURANCE CARDS, DRIVER'S LICENSE OR PHOTO ID.

ANY PATIENT WHO HAS HAD AN EVALUATION BY ANOTHER GI PHYSICIAN, PLEASE HAVE YOUR RECORDS FORWARDED TO OUR OFFICE (i.e. LABS, XRAYS, ULTRASOUND, OR PROCEDURES SUCH AS COLONOSCOPY OR EGD, etc. - OP & PATH REPORTS) PRIOR TO YOUR VISIT.

THANK YOU FOR YOUR COOPERATION. IF YOU HAVE ANY QUESTIONS PLEASE CALL OUR OFFICE AT:

943-1300 - CRANSTON	**Fax: 946-8480**
789-1860 - NARRAGANSETT	**Fax: 782-6850**
943-1301 - EAST GREENWICH	**Fax: 228-7109**
789-1860 - WESTERLY	**Fax: 789-2226**

IMPORTANT NOTICE TO ALL PATIENTS
IT IS YOUR RESPONSIBILITY TO:

1. **UNDERSTAND YOUR OWN INSURANCE COVERAGE**
2. **OBTAIN NECESSARY REFERRALS PRIOR TO YOUR VISIT**
3. **MAKE PAYMENT OF COPAY AT THE TIME OF YOUR VISIT**

WE REQUIRE 24 HOUR NOTICE IF YOU CANNOT MAKE YOUR APPOINTMENT IN THE OFFICE; OTHERWISE, THERE WILL BE A CHARGE OF $25.00

***WE REQUIRE 48 HOUR NOTICE IF YOU CANNOT MAKE YOUR APPOINTMENT FOR AN ENDOSCOPY; OTHERWISE, THERE WILL BE A CHARGE OF* $100.00**

Medication you are currently taking including vitamins

Name: _____ **Date:** _____

Date Of Birth _____ **Allergies:** _____

Pharmacy Name _____ **Location** _____

Have you had your flu shot yet this year?_____

If age 65 or older, have you had your pneumonia vaccine yet?_____ If YES, when?_____

	Name	Strength	Directions for use	Prescribing Dr.
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				

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PATIENT INFORMATION SHEET

Patient Name _____

FIRST **MIDDLE** **LAST**

Mailing Address_____

Street Address_____

City_____**State**_____**Zip**_____**Marital Status** _____

Home Phone #_____**Cell Phone #** _____ **Work Phone#** _____

Please Circle Preferred Contact Phone Number: (Home / Cell / Work **)**

Date of Birth_____**Employer** _____**Primary Language**:_____

E-mail_____

Emergency Contact _____**Relationship:** _____**Phone#**_____

Doctor/Person Referring You _____

Primary Care Physician _____

Pharmacy_____**Phone #**_____**City and State of Pharmacy**_____

MEDICAL INSURANCE COVERAGE INFORMATION

Primary Insurance Carrier_____**Insurance ID/Member#** _____
Primary Insurance Group# _____**Subscriber Name/DOB** _____

Secondary Insurance Carrier_____**Insurance ID/Member#** _____
Secondary Insurance Group# _____**Subscriber Name/DOB**_____

Tertiary Insurance Carrier_____**Insurance ID/Member#** _____
Tertiary Insurance Group#_____**Subscriber Name/DOB**_____

*****FOR MEDICARE PATIENTS ONLY*****
IN THE EVENT OUR OFFICE NEEDS TO GET PRIOR AUTHORIZATION FOR YOUR MEDICATIONS, DO YOU HAVE PRESCRIPTION DRUG COVERAGE?
Plan Name:_____ **ID #** _____

****PATIENTS WITH HEALTH INSURANCE****

I hereby authorize Gastrointestinal Medicine Associates, Inc., to release information to my insurance carrier(s) regarding my medical services and treatment in order to file a claim. I hereby assign all payments for medical services rendered to myself and dependents. I understand that I am financially liable for any co-pays, cost share, deductible, or co-insurance rendered to myself or dependents. I am responsible to pay within 30 days of my first bill or I will be subject to a 1.5% interest charge per month. If it becomes necessary to file suit to collect this bill, I agree to pay court costs and reasonable attorney fees to the extent permitted by law. A copy of this signature is valid as the original.

SIGNATURE:_____**DATE:**_____

******OVER******

****PATIENTS WITHOUT HEALTH INSURANCE****

I understand that I am financially responsible for any and all services rendered to me by Gastrointestinal Medicine Associates, Inc. Payment is due at the time of service unless other arrangements have been made. I am responsible to pay within 30 days of my first bill or I will be subject to a 1.5% interest charge per month. If it becomes necessary to file suit to collect this bill, I agree to pay court costs and reasonable attorney fees to the extent permitted by law. A copy of this signature is valid as the original.

SIGNATURE:_____DATE:_____

PLEASE CIRCLE ONE:

Race:
American Indian or Alaska Native
Asian
Native Hawaiian or Other Pacific Islander
Black or African American
White
Hispanic
Other Pacific Islander
Unreported/Refused to Report
Other Race_____

PLEASE CIRCLE ONE

Ethnicity:
Hispanic or Latin
Not Hispanic or Latin
Refused to Report

Gastrointestinal Medicine Associates, Inc.

Name_____**Date of Birth**_____

Medical History

Asthma / COPD	O Yes	O No	Obstructive Sleep Apnea	O Yes	O No
Diverticulitis	O Yes	O No	Crohn's Disease / Ulcerative Colitis	O Yes	O No
High Blood Pressure	O Yes	O No	Celiac Disease	O Yes	O No
High Cholesterol	O Yes	O No	Barrett's Esophagus	O Yes	O No
Heart disease	O Yes	O No	Peptic ulcer disease	O Yes	O No
Diabetes Mellitus	O Yes	O No	Pancreatitis	O Yes	O No
Irritable Bowel Syndrome	O Yes	O No	Ulcerative colitis	O Yes	O No
Inflammatory Bowel Disease/Colitis	O Yes	O No	Gall stones	O Yes	O No
Personal History of Colon cancer	O Yes	O No	Anemia	O Yes	O No
Personal History of Colon polyp	O Yes	O No	GERD/Reflux	O Yes	O No
Liver disease	O Yes	O No	Hemorrhoids	O Yes	O No
If Yes, what condition(s)?_____ _____			Family History of colon cancer	O Yes	O No
			Family History of Colon polyp	O Yes	O No
Have you ever been diagnosed with H.Pylori?	O Yes	O No			
Do you have a Cardiac Defibrillator or Pacemaker?	O Yes	O No			

Do you have any other chronic medical conditions: _____
_____
_____
_____

Have you had your flu shot since the most recent September 1st?_____

If you are 65 or older, have you had your pneumonia vaccine yet? _____

OVER ➡

Gastrointestinal Medicine Associates, Inc.

Name_____Date of Birth_____

Social History

Marijuana Use (in any form)	O Yes	O No	
Travel (outside the USA)	O Yes	O No	
Tattoos	O Yes	O No	
Cocaine	O Yes	O No	
IV Drugs	O Yes	O No	
Caffeine	O Yes	O No	
Smoking	O Yes	O No	packs/day_____how long_____quit____
Alcohol	O Yes	O No	drinks/day_____drinks/week_____

Family History

Mother O Alive O Deceased Age_____

O Colon cancer O Colon Polyps O Inflammatory bowel disease O Liver disease

O Other_____

Father O Alive O Deceased Age_____

O Colon cancer O Colon Polyps O Inflammatory bowel disease O Liver disease

O Other_____

Siblings O Alive O Deceased Age_____

O Colon cancer O Colon Polyps O Inflammatory bowel disease O Liver disease

O Other_____

Children O Alive O Deceased Age_____

O Colon cancer O Colon Polyps O Inflammatory bowel disease O Liver disease

O Other_____

Surgical History-Please list all surgeries, including Colonoscopy, Metal Implants

_____

_____

Medication List

Do you take:

Aspirin	O Yes	O No
Over the counter pain medication	O Yes	O No
Diabetes medication	O Yes	O No
Plavix, Coumadin, or other blood thinner	O Yes	O No

ALLERGIES: _____

Signature:_____Date:_____

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PERMISSION TO DISCUSS MEDICAL CARE

DATE:_____

PATIENT NAME:_____

PATIENT DATE OF BIRTH:_____

I,_____, will allow the physicians and staff at Gastrointestinal Medicine Associates, Inc. to discuss any and all issues concerning my medical care with:

_____
_____
_____
_____
_____
_____
RELATIONSHIP TO PATIENT:_____

NOTE: Unless Gastrointestinal Medicine Associates, Inc. is notified by you in person or by certified mail, the above PERMISSION TO DISCUSS MEDICAL CARE shall remain in effect indefinitely.

When it is necessary to contact you by telephone, i.e. to confirm or cancel an appointment, to give information to you regarding a booking or test that our office has scheduled on your behalf etc., may we call the telephone numbers which you have provided, and if you are not available may we:

_____ leave a message on your answering machine
_____ leave a message with anyone other than yourself
_____ Name of Person or Persons_____
_____
_____
_____ Anyone who answers

Telephone numbers we may call:

_____home
_____work
_____other

Signed:_____
Date:_____ witness:_____

V1.3

1150 Reservoir Avenue - Suite 201
Cranston, RI 02920
(401) 943-1300

360 Kingstown Road - Suite 202
Narragansett, RI 02882
(401) 789-1860

3461 So. County Trail - Suite 301
E. Greenwich, RI 02818
(401) 943-1300

268 Post Road - Specialty Suite
Westerly, RI 02891
(401) 789-1860

IMPORTANT!!

PATIENT PORTAL FOR GASTROINTESTINAL MEDICINE ASSOCIATES, INC.

***Once we have obtained your email address and entered it into our system*, you will receive an email with your username and temporary password to access our Portal along with the url below.**

We ask that you log onto the Patient Portal and send us a message indicating a successful connection. This is the web address:

https://health.healow.com/gimedri

The Patient Portal provides you with secure access to your:

- Vitals
- Diagnoses
- Upcoming Appointments
- Etc.

The Patient Portal is for non-urgent communications only! If you have an emergency needing clinical care, please dial 911.

This site is for your convenience and information purposes only and is not intended to treat or diagnose conditions. You can request refills, appointments, and ask questions.

Please allow 24 hours for a response to messages left on this site.