GASTROINTESTINAL MEDICINE ASSOCIATES, INC.

www.GIMEDRI.com

PAUL W. RODERICK, M.D., F.A.C.G.
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OPEN ACCESS PAPERWORK

Please complete the enclosed paperwork and return to our office as soon as completed.

We require a copy of your health insurance card (front and back), insurance referral (if your insurance plan requires one), and driver's license to be enclosed with the paperwork.

Once the required paperwork is returned to our office and we receive the required information from your primary care physician, we will call you to schedule the procedure. Also at that time, we will mail to you the preparation instructions and forms necessary for the facility where you will be having your procedure.

Some forms are double sided.
Any missing information will delay the process.

Alternatively, you may complete the forms electronically on our website www.GIMEDRI.com, by clicking on the "Screening Colonoscopy Form" button on our home page.

If you have any questions regarding this, please call our office at 401-943-1300 for the Cranston office or 401-789-1860 for the Narragansett office

Thank you, Gastrointestinal Medicine Associates, Inc.

V1.4

Request for Open Access Colonoscopy

Please fill out the following information AND provide a copy of your insurance card and driver's license and mail to our office.

NAME:____________________D.O.B.:_____________________ Age:_______

Height:__________ Weight:___________

Primary Care Physician: ________________________

Date of Last Office Visit: _______________________

Reason for colonoscopy: ____Screening – 50 or older

____Family history of colon cancer or precancerous polyp
Which relative? ______________

_____Previous colonoscopy showing polyps

Date of prior exam, physician and name of facility _____________________________
________Prior history of colitis?

MEDICATIONS AND DOSAGES(Please list all prescription and over the counter medications you currently take). A separate sheet is enclosed to record these.

Do you take: Aspirin **Yes** **No**
Over the counter pain medication **Yes** **No** If yes, which one: __________________
Diabetes medication **Yes** **No** If yes, which one:______________________________
Plavix, Coumadin or other blood thinners **Yes** **No** If yes, which one:______________
Do you have a diagnosis of obstructive sleep apnea? **Yes** **No**

LIST ALL ALLERGIES:
____

----OVER----

 Name:______________________________________

PAST MEDICAL HISTORY (List all chronic medical conditions you have been diagnosed with)

_____________________________________ _________________________________

_____________________________________ _________________________________

_____________________________________ _________________________________

PAST SURGERIES (Please list all prior surgeries)

_____________________________________ _________________________________

_____________________________________ _________________________________

_____________________________________ _________________________________

FAMILY HISTORY

_____________________________________ _________________________________

_____________________________________ _________________________________

SOCIAL HISTORY (I.E., SMOKING, ALCOHOL, CAFFEINE, DRUGS)

_____________________________________ _________________________________

_____________________________________ _________________________________

Have you had excessive or prolonged bleeding from previous injury or surgery? YES NO
Do you have any metal implants in your body (i.e., joint replacement)? YES NO
Do you have a pacemaker or cardiac defibrillator? YES NO

Patient Signature____ **Date**________________

Physician Signature____ **Date**________________
THIS IS FOR GASTROINTESTINAL MEDICINE ASSOCIATES,INC. USE ONLY

THIS FORM MUST BE RETURNED TO OUR OFFICE AS SOON AS POSSIBLE

MEDICATION YOU ARE CURRENTLY TAKING INCLUDING VITAMINS

Name:________________________________Date of Birth:____________Date:____________

Allergies:____

Pharmacy Name:________________________Location:______________________________

Medication Name	Strength	Directions for Use	Prescribing Provider

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PATIENT INFORMATION SHEET

Patient Name____

FIRST MIDDLE LAST

Mailing Address____

Street Address____

City_____________________**State**_______________**Zip**__________

Home Phone #__________________**Cell Phone #**__________________

Work Phone #__________________**Date of Birth**_________________

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

Marital Status ______________

Employer____

E-mail____

Emergency Contact ____

Relationship to Patient___________________**Phone#**______________

Doctor/Person Referring You__________________________________

Primary Care Physician______________________________________

Pharmacy_________________________**Phone #**_________________

City and State of Pharmacy___________________________________

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

Primary Language:_________________________

OVER

MEDICAL INSURANCE COVERAGE INFORMATION—PAGE 2

Primary Insurance Carrier____
Primary Insurance ID/Member #_______________________________________
Primary Insurance Group #____
Subscriber Name____________________________ **Date of Birth**_____________

Secondary Insurance Carrier____
Secondary Insurance ID/Member #_____________________________________
Secondary Insurance Group #____
Subscriber Name____________________________ **Date of Birth**_____________

Tertiary Insurance Carrier____
Tertiary Insurance ID/Member #_______________________________________
Tertiary Insurance Group # ____
Subscriber Name____________________________ **Date of Birth**_____________

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:**_____________

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:**________________

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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:______

V1.1

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.