THE CENTER FOR GASTROINTESTINAL DISORDERS

4350 SHERIDAN STREET SUITE 101
HOLLYWOOD, FL 33021

PATIENT HISTORY INTAKE SHEET

I. PATIENT INFORMATION

Date: _____

Full Name: _____ Date of Birth: _____

II. CHIEF COMPLAINT

What is the main reason for your visit today?

_____

_____

III. MEDICATIONS

List all current medications, vitamins, and supplements:

1. _____
2. _____
3. _____

☐ See attached list

IV. ALLERGIES

☐ No known drug allergies

☐ Yes – List: _____

_____

☐ See attached list

V. SOCIAL HISTORY

Tobacco Use: ☐ Never ☐ Former ☐ Current – Packs/day: _____

Alcohol Use: ☐ No ☐ Yes – Drinks/week: _____

Drug Use (recreational): ☐ No ☐ Yes – Type: _____

Occupation: _____ Marital Status: ☐ S ☐ M ☐ D ☐ W

VI. MEDICAL HISTORY (Check all that apply)

☐ High blood pressure ☐ Diabetes ☐ Heart disease ☐ Seizures ☐ Anemia

☐ Sleep apnea ☐ Kidney disease ☐ Thyroid disorder ☐ HIV/AIDS ☐ Hepatitis A / B / C

☐ Cancer (Type: _____)

Other conditions: _____

_____

VII. SURGICAL HISTORY

List any surgeries and dates:

1. _____ 2. _____ 3. _____

VIII. FAMILY HISTORY

Any relatives with the following conditions?

☐ Colon cancer ☐ Stomach cancer ☐ Liver disease ☐ Crohn's/Colitis ☐ Polyps ☐ Pancreatitis ☐ Ulcers

☐ Other GI issues: _____

IX. GI PROCEDURE HISTORY

Last Colonoscopy: _____ ☐ Normal ☐ Abnormal

Last Upper Endoscopy (EGD): _____ ☐ Normal ☐ Abnormal

Prior GI Surgeries: _____

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X. REVIEW OF SYSTEMS (Check if currently experiencing)

GENERAL:

☐ Fatigue ☐ Weight loss
☐ Fever ☐ Anemia
☐ Bruise Easily / Bleed too Long
☐ Cancer (Type: _____)
☐ Diabetes ☐ Thyroid disorder

GASTROINTESTINAL:

☐ Diarrhea ☐ Constipation
☐ GERD/Heartburn ☐ Stomach Cramps
☐ Blood in stool ☐ Bloating
☐ Liver disease ☐ Gas
☐ Difficulty swallowing ☐ Jaundice

EARS, EYES, NOSE, THROAT:

☐ Ring in Ears ☐ Sinus Issues
☐ Ear Infections ☐ Hoarseness
☐ Dizzy Spells ☐ Eye Infection
☐ Poor Vision ☐ Cataracts
☐ Glaucoma

URINARY:

☐ Urine Infection
☐ Blood in Urine
☐ Decrease in Urine Flow/Force
☐ Urination at Night (>2 Times)

PULMONARY:

☐ Pneumonia ☐ Bronchitis
☐ Asthma/COPD ☐ Cough
☐ Shortness of breath

BONES & JOINTS:

☐ Arthritis/Rheumatism
☐ Back Pain ☐ Gout
☐ Osteoporosis

CARDIAC:

☐ Chest pain ☐ Palpitations
☐ High Blood Pressure ☐ Ankle Swelling
☐ Irregular heartbeat ☐ Phlebitis (Blood Clots)

NEUROLOGIC:

☐ Stroke ☐ Tremors/Shaking
☐ Numbness / Tingling
☐ Headaches ☐ Migraines

SKIN:

☐ Rash ☐ Hives
☐ Allergic Reaction

PSYCHIATRIC:

☐ Depression ☐ Panic Attacks
☐ Anxiety

XI. ATTESTATION

I confirm the information provided is accurate and complete to the best of my knowledge. I understand this information is necessary for proper medical care.

Patient Signature: _____ Date: _____

THE CENTER FOR GASTROINTESTINAL DISORDERS

MEDICAL RECORDS REQUEST & PATIENT AUTHORIZATION

To: Releasing Provider/Facility

Name/Practice: _____ Fax: _____

We are requesting medical records for the patient listed below for the purpose of continuity of care. Please release the requested information to our office.

Patient Information

Full Name: _____ Date of Birth: _____

Records Requested

☐ Complete Medical Record ☐ Gastrointestinal (GI) Procedure Reports ☐ Pathology Reports

☐ Laboratory Results ☐ Imaging Studies ☐ Consult Notes / Office Visits

☐ Other (specify): _____

Delivery Instructions

Please send records to:

Mark Lamet MD PA dba The Center for Gastrointestinal Disorders

Address: 4350 SHERIDAN STREET SUITE 101, HOLLYWOOD, FL 33021

Fax: 855-269-3271 Phone: 954-961-7771

Patient Authorization (HIPAA Compliance)

- I hereby authorize the above-named provider/facility to release my medical records to The Center for Gastrointestinal Disorders for the purpose of my ongoing care.
- I understand this may include information on HIV/AIDS, mental health, genetic testing, and substance abuse treatment.
- I understand that once records are released, they may be subject to redisclosure by the recipient.
- This authorization is valid for one year from the date signed unless revoked in writing earlier.
- I understand revocations must be submitted in writing to The Center for Gastrointestinal Disorders, Attention: Administrator Maria Navarro. Revocations will not be effective until received and acknowledged by the Administrator.

Signature: _____ Relationship to Patient (if applicable): _____

Print Name: _____ Date: _____

For Office Use Only

Request sent on: _____ / _____ / _____ By (staff initials): _____

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4350 SHERIDAN STREET SUITE 101
HOLLYWOOD, FL 33021
PH: 954-961-7771 FAX: 954-989-2327

PATIENT FINANCIAL RESPONSIBILITY AND CANCELLATION CONSENT FORM

Patient Name: _____ Date of Birth: _____

1. **DEDUCTIBLES AND OUT-OF-POCKET RESPONSIBILITIES:**

If your insurance plan includes an outstanding deductible or out-of-pocket responsibility related to your scheduled procedure, you are required to pay **50%** of that estimated responsibility at the time of scheduling.

2. **CANCELLATION POLICY:**

If you need to cancel or reschedule your procedure OR office visit, you must notify our office at least 48 hours prior to your scheduled appointment.
- Failure to cancel within **48 hours** will result in a **$50.00 fee**.

3. **CREDIT CARD ON FILE REQUIREMENT:**

This card will only be charged in the event of a late cancellation or no-show as described above, or to process any remaining balance after insurance payment, if applicable.

I _____ acknowledge that I have read and understand my financial responsibility and the cancellation policy of MARK LAMET MD PA dba THE CENTER FOR GASTROINTESTINAL DISORDERS.

Patient/Authorized Representative Signature: _____

Date: _____

Staff Member Name: _____ Date: _____

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CREDIT CARD AUTHORIZATION FORM

Patient Information

Full Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Email: _____

Credit Card Information (All information is kept strictly confidential)

Card Type: ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Name on Card: _____

Card Number: _____

Expiration Date: _____ / _____ CVV (Security Code): _____ Billing Zip Code: _____

Authorization

I authorize MARK LAMET MD PA dba THE CENTER FOR GI DISORDERS to keep my credit card information securely in file. I understand that my card may be charged for:

1. Any scheduled procedure(s) or related services.
2. Outstanding balances on my account.
3. Cancellation or no-show fees, if applicable, per office policy.

I acknowledge that this authorization will remain in effect until I provide written notice of cancellation to MARK LAMET MD PA dba THE CENTER FOR GI DISORDERS, and that such cancellation will not affect charges made prior to the receipt of my cancellation request.

I certify that I am an authorized user of this credit card and will not dispute charges with my credit card company for payments made in accordance with this authorization form.

Signature: _____ Date: _____

Printed Name: _____