10210 East 91st Street South
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(918) 940-8500

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Geoffrey A. Fillmore, D.O.

Gastroenterology Specialists, Inc.

Email Address:			Social Security Number: __ __ __ - __ __ - __ __ __ __
Last Name:	First:	MI:	Home #: ( ) -
Address:			Work #: ( ) -
City:	State:	Zip:	Cell #: ( ) -
I give GSI permission to leave a voicemail message at this number: Home: ☐ Work: ☐ Cell: ☐			
Date of Birth:	Marital Status:		Gender:
Referring/Primary Physician:			Employer:
Emergency Contact Name:			Relationship to patient:
Emergency Contact Phone #: ( ) -			
Primary Insurance:			Card Holder's Name:
Card Holder's SSN#:	DOB:		Card Holder's Employer:
ID#:	Group #:		Claim Address:
City:	State:		Zip:
Secondary Insurance:			Card Holder's Name:
Card Holder's SSN#:	DOB:		Card Holder's Employer:
ID#:	Group#:		Claim Address:
City:	State:		Zip:

By signing below, I acknowledge I have received GSI's Privacy Policy, Financial Policy, and Patient Rights & Responsibilities:
Please remember that insurance is considered a method of reimbursing the patient for fees paid to the physician and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. I hereby assign all medical and/or surgical insurance benefits to which I am entitled to Gastroenterology Specialists, Inc. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all changes whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient record, which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS), until otherwise revoked in writing by the patient or guardian.

Patient Signature:	**Date:**

If preferred, you may wait to sign this form until you receive these policies in our office.
GSI's Privacy Policy, Financial Policy, and Patient Rights & Responsibilities are available in our office, by mail if requested, or on our website at: www.gsitulsa.com

Please bring these completed forms, your insurance card(s), and a photo ID to your appointment.

A $50 fee may be charged for missed appointments or appointments rescheduled without sufficient notice.

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Authorization to Release Medical and Financial Information

This authorization covers all services rendered to me, or the patient I am signing for, today and all future dates of service until revoked in writing. I understand I may revoke this authorization by informing Gastroenterology Specialists, Inc. in writing at any time.

I authorize Gastroenterology Specialists, Inc. to release any medical or financial information to the individuals and entities listed below including:

-All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, photographs.

-All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse, communicable and/or non-communicable disease. I authorize the release or disclosure of this type of information. There are no limitations placed on dates, history of illness or diagnostic and therapeutic information, including any treatment of alcohol/drug abuse, HIV-AIDS, or psychiatric treatment.

(Gastroenterology Specialists, Inc. may not release information or records to any individual or entity unless you identify them here):

Name_____ (Date of Birth __/__/____) Relationship_____

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Name_____ (Date of Birth __/__/____) Relationship_____

Signature _____ **Date** ____/_____/_____

Patient Name _____ **Patient's Date of Birth** ___/___/_____

Full Name: _____ **DOB**: _____
Date of Appointment: _____

Why are you here

Please describe in your own words:

When did your symptoms start?

Are your symptoms:	Constant: ☐	Intermittent: ☐

Were you given any medications for your symptoms? Yes ☐ No ☐

Please list them:

Have you ever been on any of the following medications?

(check all that apply)

Prilosec (prescription or over the counter): ☐	Aciphex: ☐
Nexium: ☐	Prevacid: ☐
Protonix: ☐	Hyoscyamine/Levsin/Levsid: ☐
Dicyclomine/Bentyl: ☐	Librax: ☐

Have you ever had (please list date)

EGD/upper endoscopy: ☐	Colonoscopy: ☐
Flexible sigmoidoscopy: ☐	CT of the abdomen: ☐
Ultrasound of the abdomen: ☐	Upper GI series (x-ray test):
Barium enema (x-ray test): ☐	Abdominal x-rays: ☐

Full Name: _____ **DOB**: _____

Medication Allergies:	

Medications: (please list all medications you are currently taking, including any over the counter medications and dietary/herbal supplements) You may attach a written list:

Medication Name	**Dosage/how often**	**When started**

Do you take (check all that apply)

Aspirin: ☐	Ibuprofen: ☐
Motrin: ☐	Advil: ☐
Aleve: ☐	Naprosyn: ☐

Medical history (check all that apply)

Heart attack: ☐	Depression: ☐
Heart disease/irregular heart beat: ☐	Anxiety: ☐
Congestive heart failure: ☐	Bipolar disorder: ☐
COPD/emphysema: ☐	Panic disorder/panic attacks: ☐
Asthma: ☐	Endometrosis: ☐
High blood pressure: ☐	Arthritis: ☐
Diabetes: ☐	Stomach ulcers: ☐
High cholesterol or triglycerides: ☐	Pancreatitis: ☐
Thyroid disease: ☐	Colon polyps: ☐
Seizure disorder/epilepsy: ☐	Diverticulosis: ☐
Bleeding problems: ☐	Diverticulitis: ☐
Blood transfusions: ☐	GERD/acid reflux: ☐
Anemia: ☐	Irritable bowel syndrome: ☐
Sleep apnea: ☐	Spastic colon: ☐
Alcoholism: ☐	Gallbladder disease: ☐
Migraine Headache: ☐	Crohns: ☐
Cancer: ☐	Ulcerative Colitis: ☐
Other: ☐	

Full Name: _____ **DOB**: _____

Surgical history (check all that apply)

Gallbladder: ☐	Ulcer surgery: ☐	Hernia repair: ☐
Pacemaker/defibrillator: ☐	Appendectomy: ☐	Reflux surgery: ☐
Hysterectomy: ☐	Heart stents: ☐	Colon surgery: ☐
Gastric bypass: ☐	Heart bypass: ☐	Heart valve replaced: ☐
Other: ☐		

Have you ever had a bad reaction to anesthesia?: Yes ☐ No ☐

Demerol: ☐	Valium: ☐
Versed: ☐	Fentanyl: ☐

Social history:

Occupation:	Marital status:
Hobbies:	
Do you smoke: Yes ☐ No ☐	How much:
Do you use alcohol: Yes ☐ No ☐	How much:
Do you use oral tobacco: Yes ☐ No ☐	How much:

Full Name: _____ **DOB**: _____

Family history: (check all that apply and indicate which family member)		
Colon cancer: ☐	Colon polyps: ☐	Stomach cancer: ☐
Esophagus cancer: ☐	Pancreas cancer: ☐	Liver cancer: ☐
Breast cancer: ☐	Ovarian/uterine cancer: ☐	Crohn's disease: ☐
Ulcerative colitis: ☐	Irritable bowel: ☐	Stomach ulcers: ☐
Gallbladder disease: ☐	Celiac disease/wheat allergy: ☐	Cirrhosis: ☐
Hepatitis: ☐	Other: ☐	

Do you have an Advanced Care Plan, Living Will or a Surrogate decision maker: Yes ☐ No ☐

Full Name: _____**DOB**: _____

Review of GI symptoms (check all that apply to you)			
Weight loss: ☐ How much?		When did weight loss start:	
Decreased appetite: ☐		Fever: ☐	
Abdominal pain after eating: ☐			
Abdominal pain improved by: ☐			
Belching: ☐	Passing gas: ☐	Eating: ☐	Bowel movement: ☐
Location of abdominal pain: ☐			
Upper: ☐	Lower: ☐	Right: ☐	Left: ☐
Around belly button: ☐			
Nausea after eating: ☐		How long after: ☐	
Vomiting after eating: ☐		How long after: ☐	
Heartburn: Day: ☐	Night: ☐	Both: ☐	
Reflux: Day: ☐	Night: ☐	Both: ☐	
Difficulty swallowing or food getting stuck when you swallow: ☐			
Jaundice: ☐		Constipation: ☐	
Abdominal pain associated with constipation: ☐		Mucous with stool: ☐	
Bloating: ☐		Diarrhea: ☐	
Number of bowel movements per day: ☐		Diarrhea that wakes you up at night: ☐	
Do you travel outside the country?: ☐		Do you consume well water or fresh water on a regularbasis?: ☐	
Have you had antibiotics recently (within the last 6months)?: ☐		Red blood in or with your stool: ☐	
Bloody diarrhea: ☐		Black stools: ☐	
Do certain foods make your abdominal symptoms worse? Yes ☐ No ☐ (If yes, please list)			