Gastroenterology

1600 N. Grand Ave, Pueblo, CO 81003
Suite150 – 719.595.7680 / Suite 345 – 719.562.2290
Fax: 719.595.7687

Paula Dionisio, M.D. * Lirio Polintan, M.D. * Charles Ruzkowski, M.D. * Barbara Niven PA-C
Nicole Pisapia, D.O. * Brenton Rogers, D.O. * Noah Settergren, D.O.*
Jimmy Giang, D.O. * Neha Vohra Kaiser, D.O. * Joseph Chapman, D.O. * Karolina Siniakowicz, D.O.

Date _______________________

Dear Patient ___________________
In anticipation of your appointment on ________________________ at ____________, with Dr.________________________________ in Suite ____________ we felt it would be helpful for you to complete the enclosed patient packet. Please bring your completed forms, insurance cards, photo ID and a current list of medications with you. **You should plan on arriving 15 minutes prior to your appointment.** If applicable, you will also be expected to pay your copayment.

Please be courteous and contact our office if you are unable to make your appointment. We require a 24 hour notice for any cancellations or rescheduled appointments.

If you are a Pueblo Community Health Center patient and have CICP insurance, you **MUST** contact PCHC at 543.8711 to see if you are required to have a referral for your visit. If you do not have the referral at the time of your appointment you may be liable for the charges.

Feel free to call our office at 719.595.7680 option 3 if you have any questions. We look forward to seeing you soon.

Sincerely,
Parkview Gastroenterology

## Patient Information

Name: ______________________________________________________________________________
Last First MI

Address: ____________________________________________________________________________
Street City/State ZipCode Phone:

(_____)_______________________(_____)______________________________(_____)_________________________
Main/Home Main/Cell Main/Work EX

Date of Birth: _______/________/_______ Social Security #: ________--______--_______ Marital Status: M / W / D / S Sex: M / F

Email Address: ____________________________________________@________________________ Primary Care Physician: __________________________________ Phone: (_____) __________________ Main Pharmacy: _______________________________________ Phone: (_____) __________________

### Patient Employer Information

Employer Name: ___________________________________________________________________________ Address: _____________________________________________________ Employer Phone: (_____) ___________________
Street City/State ZipCode Main/Work

### In Case of Emergency Notification

Name: ______________________________________________________________________________
Last First MI

Address: ____________________________________________________________________________
Street City/State ZipCode Phone:

(_____)____________________(_____)_____________________________________(_____)_______________________
Main/Home Main/Cell Main/Work EX

### Responsible Party

Name: ______________________________________________________________________________
Last First MI

Address: ____________________________________________________________________________
Street City/State ZipCode Phone:

(_____)_______________________________(_____)______________________________(_____)_______________________
Main/Home Main/Cell Main/Work EX

Employer Name: ______________________________________________________________________

Address: _______________________________________________________ Employer Phone: (_____) ___________________
Street City/State Zip Code Main/Work

### Insurance Information

Primary Insurance: ____________________________________________________________________

Policy Holder Name: ______________________________________________ Relationship: ___________________________

Plan #: ____________________________ Member #: _______________________ Group #: ___________________________

Secondary Insurance: __________________________________________________________________

Policy Holder Name: ______________________________________________ Relationship: ___________________________

Plan #: ____________________________ Member #: _______________________ Group #: ___________________________

I authorize treatment of the person named above and agree to pay all fee and changes for such treatment. I understand that all charges are due and payable at the time of service. I am also aware that if insurance does not cover services, I am responsible for all charges. I authorize payment of insurance benefits directly to Parkview Gastroenterology. I authorize release of medical information needed to complete insurance company claim inquires, quality assurance and utilization management activities.

**Signature:** ____________________________________________________________**Date:**_______________

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Effective April 14, 2003 federal privacy law limited our ability to disclose your health information to others, including to your **family members**. The privacy law now requires that every adult person must give written authorization before we may disclose your health or medical information to another person, including **family members** such as a **spouse**.

If you would like us to disclose your health and medical information to anyone besides yourself, please complete the following:

I, ______________________________________________________, _________________________,

**Patient name** **Date of Birth**

authorize you to disclose information as needed to the following individual(s):

(1)_____________________________________________________________________________________

Name Relationship

_____________________________________________________________________________________

Address Phone

(2)_____________________________________________________________________________________

Name Relationship

_____________________________________________________________________________________

Address Phone

(3)_____________________________________________________________________________________

Name Relationship

_____________________________________________________________________________________

Address Phone

_____________________________________________________________________________________

**Signature** **Date**

Patient Portal

Access your own personal Patient Portal online:

https://health.eclinicalworks.com/Parkview

Patient Name: ___________________________________________

(Please Print Clearly)

☐ Yes, I would like to be Web Enabled

Preferred Email Address: ____________________________________

(Please Print Clearly)

☐ No, I would not like to be Web Enabled

☐ I do not have an email

☐ I do not want to share my email

☐ Other ______________________________________________

Signature: ____________________________________________________

Date

*The Patient Portal is secured by Secure Sockets Layer SSL which is the standard security technology for creating an encrypted link between a web server and a browser. This ensures that all data passed between you and your provider remains private and integral.*

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Patient Name: ______________________________________________________ Date: ___________
DOB: _________________ Age: ________ Referring Provider/PCP: ____________________
Reason for visit: ______________________________________________________________________

Hep A Vaccine: __________ Hep B Vaccine: __________ TB Skin Test: __________

Please list **ALL** medications you are currently taking including **aspirin** and over the **counter medications, vitamins**, and **herbs**.

| Medicine | Dose / Frequency | Condition | How Long On Medication |
|---|---|---|---|
| | | | |
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Do you take **COUMADIN / WARFARIN** or any other prescription blood thinner? Yes ____ No _____ Allergies:
Please list all allergies and reaction:
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Please list ALL past surgeries, illness and hospitalizations:
_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

If you have had any of the following procedures please indicate when: EGD: ________ Colonoscopy: ________
Sigmoidoscopy: ________ Upper GI X-Ray: ________ Barium Enema: ________ Stool Guiac Study: ________

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**Social History**

**Patient Name:** ________________________________________________________DOB: _____________
**Marital Status:** Single / Married / Divorced / Widowed **Occupation:** ____________________________
**How many people live in the home:** __________ **# of Children** _________
**Smoking History:** Never / Quit/YR______ YES / #of pks per day ________ #yrs ________
**Alcohol use:** NONE / RARE / Quit/YR ________ YES/amount per week ________
**Nasal Cocaine use:** YES / NO IV Drug use YES / NO Last used (YR) _________ Tattoos: YES / NO
**Blood Transfusion:** YES / NO (year _____) **Body Piercings:** YES / NO **Exercise:** YES / NO **Coffee:** YES / NO If yes how many cups per day? ____

**Do you use oxygen at home?** YES / NO If YES How many liters? _________
**Have you been told that you need antibiotics prior to dental procedures?** YES / NO **Do you have hearing aids?** YES / NO **Do you have dentures, partials or any loose teeth?** YES / NO **Do you require any special equipment or have special needs?** YES / NO **Do you use contraceptives?** YES / NO
**WOMAN ONLY:** Could you be pregnant? YES / NO Last menstrual period: __________

**Personal and Family History**
**Circle ALL that Apply and Note S=Self M=Mother F=Father SB=Sister/Brother C=Child**

COLON CANCER LIVER DISEASE/FAILURE LEUKEMIA STROKE
COLON POLYPS HEART DISEASE LYMPHOMA PANIC ATTACK
COLITIS / CROHN'S HIGH BLOOD PRESSURE BREAST CANCER ALCOHOLISM
ANXIETY / DEPRESSION CELIAC SPRUE EMPHYSEMA UTERINE CANCER
ACID REFLUX ASTHMA OVARIAN CANCER DRUG ABUSE
PEPTIC ULCER / HPYLORI CYSTIC FIBROSIS CERVICAL CANCER STD's
GALLSTONES SLEEP APNEA KIDNEY DISEASE HIV / AIDS
PANCREATITIS TUBERCULOSIS DIABETES PANCREATIC CANCER
HEMACHROMATOSIS SEIZURE / EPILEPSY ANEMIA
ESOPHAGEAL CANCER BLEEDING DISORDER MIGRAINES HEP A/B/C
AIZHEIMER'S DEMENTIA ANESTHESIA REACTION OTHER________________________________

**Circle ALL Symptoms YOU CURRENTLY have OR have had in the past**

WEIGHT LOSS COUGH FREQUENT URINATION MEMORY LOSS
FEVER / CHILLS SHORTNESS OF BREATH ARTHRITIS / JOINT PAIN DEPRESSION
NOSE BLEEDS HEART BURN NEW OR CHRONIS RASH ANXIETY
HOARSENESS NAUSEA / VOMITING HEADACHES HOT/COLD SENSITIVITY CHEST PAIN DIFFICULTY / SWALLOWING SEIZURES EXCESSIVE THIRST
IRREGULAR HEART BEAT PAIN w/SWALLOWING SWELLING ANKLES / LEGS EASY BRUISING
DIARRHEA ABDOMINAL PAIN CONSTIPATION BLOOD IN STOOL
**OTHER:** ______________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

# Office Policies & HIPAA Disclosure

- Routine prescriptions will be refilled within 72 hours. Please plan ahead for your refills. Please be aware that the on-call physician may not be familiar with your care and may by unable to refill sedative or narcotic prescriptions.

- In the event that you would be unable to attend your appointment, please contact our office at least 24 hours prior to the appointment time to notify us of your cancellation.

- After two missed appointments without the appropriate prior notification to cancel or reschedule, we reserve the right to dismiss you as a patient from our practice.

- Co-pays are expected at the time of service in the office.

- Physician and/or medical assistants will return telephone messages within one business day.

- If you believe that your condition is life threatening, please call 911 before trying to reach the office or the physician on call.

- If you receive a prescription for a “controlled” (Schedule II through V) medication, your identifying prescription information will be entered into Colorado’s electronic Prescription Drug Monitoring Database (PDMP). This information may be accessed for limited purposes by specified individuals within the office.

- Your external prescription medication history will be accessed by specified individuals within the office for the purpose of verifying your medications and checking for insurance plan participation.

## HIPAA

- I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:
    - ✓ Conduct, plan and direct my treatment and follow-up with the multiple healthcare providers who may be involved in that treatment directly and indirectly.
    - ✓ Obtain payment from third-party payers.
    - ✓ Conduct normal healthcare operations such as quality assessments and physician certifications.
- I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that PMG has the right to change its Notices of Privacy Practices from time to time, and that I may contact this office at any time to obtain a current copy of the Notice of Privacy Practices.

- The Federal Health Information Portability and Accountability Act (HIPAA) require that we give you a full description of the ways in which we both use and protect your health information in our Notice of Privacy Practices. Please sign below to acknowledge receipt of the Notice. We encourage you to read our Notice and ask questions