

ALABAMA DIGESTIVE DISEASES, P.C.

985 - 9T1-1 AVENUE S.W.

SUITE 307

BESSEMER, ALABAMA 35022

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2650 10TH AVENUE SOUTH

SUITE 610

BIRMINGHAM, ALABAMA 35205

PHONE: (205) 933.2691

NAME _____ BIRTH DATE _____

ADDRESS _____ CITY, STATE, ZIP _____

PHONE (H) _____ (W) _____

SOCIAL SECURITY NO _____ MARITAL STATUS M S D W (CIRCLE)

EMPLOYER _____ PHONE _____

EMPLOYER'S ADDRESS _____ OCCUPATION _____

NAME OF SPOUSE/GUARDIAN _____

ADDRESS _____ PHONE _____

NEAREST RELATIVE NOT LIVING WITH YOU _____

ADDRESS _____ PHONE _____

FAMILY PHYSICIAN _____ REFERRED BY _____

PERSON RESPONSIBLE FOR PAYMENT _____ PHONE _____

ADDRESS _____

INSURANCE COMPANY Primary _____ POLICY NO. _____

INSURANCE COMPANY Secondary _____ POLICY NO. _____

I understand that I am a patient of ALABAMA DIGESTIVE DISEASES, P.C. and that he has the right to designate the persons who will perform professional services for me.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: The hospital and attending physician are authorized to furnish medical information requested by insurance companies with whom I have coverage or any public agency which may be assisting in payment of my care.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment directly to ALABAMA DIGESTIVE DISEASES, P.C. of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but not to exceed the physicians regular charges for these services. I understand that I am financially responsible to ALABAMA DIGESTIVE DISEASES, P.C. for charges not covered by this assignment. I authorize the refund of overpaid benefits where by coverages are subject to coordination of benefits. In the event of default, I agree to pay all costs of collection including reasonable attorney's fees, waiver all claims of exemption under the law of the State of Alabama.

SIGNATURE OF PATIENT (Parent or Guardian of Minor) _____

Date _____

ALABAMA DIGESTIVE DISEASES,

MEDICAL & FAMILY HISTORY FORM

NAME:

DATE OF BIRTH: _____ TODAY'S DATE'

Medications — Please list all of your current prescription and non-prescription medications, vitamins and supplements:

None

Past Medical History

- | | | | | |
|--|--|--|---|--|
| <input type="checkbox"/> Acid reflux
<input type="checkbox"/> Anemia
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Asthma
<input type="checkbox"/> Bleeding disorder
<input type="checkbox"/> Blood clots
<input type="checkbox"/> Blood transfusion
<input type="checkbox"/> Cancer
<input type="checkbox"/> Chest pain/angina
<input type="checkbox"/> Chronic anxiety
<input type="checkbox"/> Chronic cough
<input type="checkbox"/> Chronic lung disease
<input type="checkbox"/> Chronic sinusitis | <input type="checkbox"/> Cirrhosis of liver
<input type="checkbox"/> Colon cancer
<input type="checkbox"/> Colon polyps
<input type="checkbox"/> Crohn's disease
<input type="checkbox"/> Depression
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Diverticulitis
<input type="checkbox"/> Duodenal ulcer
<input type="checkbox"/> Emphysema
<input type="checkbox"/> Fatty liver
<input type="checkbox"/> Gallstones
<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Gout | <input type="checkbox"/> Groin hernia
<input type="checkbox"/> Heart attack
<input type="checkbox"/> Heart failure
<input type="checkbox"/> Heart murmur
<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Hiatal hernia
<input type="checkbox"/> High blood pressure
<input type="checkbox"/> High cholesterol
<input type="checkbox"/> High triglycerides
<input type="checkbox"/> HIV or AIDS
<input type="checkbox"/> Irregular heart beat
<input type="checkbox"/> Irritable bowel syndrome
<input type="checkbox"/> Kidney disease/failure | <input type="checkbox"/> Kidney infection
<input type="checkbox"/> Kidney stones
<input type="checkbox"/> Lupus
<input type="checkbox"/> Migraines
<input type="checkbox"/> Milk intolerance
<input type="checkbox"/> Multiple sclerosis
<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Ovarian cyst
<input type="checkbox"/> Pancreatitis
<input type="checkbox"/> Parkinson's disease
<input type="checkbox"/> Peptic ulcer
<input type="checkbox"/> Phlebitis
<input type="checkbox"/> Pneumonia | <input type="checkbox"/> Polio
<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Radiation therapy
<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Sciatica
<input type="checkbox"/> Seizures
<input type="checkbox"/> Sleep apnea
<input type="checkbox"/> Stomach ulcer
<input type="checkbox"/> Stroke .or paralysis
<input type="checkbox"/> TB (Tuberculosis)
<input type="checkbox"/> TB skin test positive
<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Ulcerative colitis |
|--|--|--|---|--|

Allergies

None Penicillin Sulfa Aspirin Iodine Latex Others: _____

Surgeries/Procedures

- | | | | | | |
|---|---|---|--|---|--|
| <input type="checkbox"/> None
<input type="checkbox"/> Appendectomy
<input type="checkbox"/> Breast
<input type="checkbox"/> Colon surgery
<input type="checkbox"/> Colonoscopy | <input type="checkbox"/> Colostomy
<input type="checkbox"/> C-section
<input type="checkbox"/> EGD
<input type="checkbox"/> ERCP
<input type="checkbox"/> Gallbladder | <input type="checkbox"/> Groin hernia
<input type="checkbox"/> Heart bypass
<input type="checkbox"/> Heart stent
<input type="checkbox"/> Heart valve
<input type="checkbox"/> Hemorrhoid surgery | <input type="checkbox"/> Hiatal hernia repair
<input type="checkbox"/> Hysterectomy
<input type="checkbox"/> Joint replacement
<input type="checkbox"/> Kidney
<input type="checkbox"/> Liver biopsy | <input type="checkbox"/> Obesity surgery
<input type="checkbox"/> Ovary
<input type="checkbox"/> Prostate
<input type="checkbox"/> Sigmoidoscopy
<input type="checkbox"/> Stomach | <input type="checkbox"/> Thyroid
<input type="checkbox"/> Tonsillectomy
<input type="checkbox"/> Tubal ligation
<input type="checkbox"/> Uterus
<input type="checkbox"/> Other _____ |
|---|---|---|--|---|--|

Previous Hospitalizations

Reason	Date	Reason	Date

Family History

	Father	Mother	Grandparents	Siblings	Children
Healthy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deceased	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon polyps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcer disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pancreas disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcerative colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes mellitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Social History

Marital status married single divorced widowed
 Occupation: _____ unemployed retired
 Smoking history: never yes; _____ packs per day for _____ years
 Currently smoking? no yes
 Other tobacco use no yes; details: _____
 Alcohol use no yes; amount per day: _____ for _____ years
 Drug use no yes; specify drugs and amounts: _____
 Exercise no yes; how much and how often: _____
 Hobbies none yes; specify: _____
 Recent travel outside US no yes; where: _____

Review of Systems – check all that apply at the present time

General

- fever or chills
- loss of appetite
- weight gain
- weight loss
- weakness, fatigue

Gastrointestinal

- abdominal distention
- abdominal pain/cramping
- belching
- black stools
- blood in stool
- change in bowel habits
- constipation
- diarrhea
- difficulty swallowing
- fat intolerance
- full after eating small amounts
- gas/bloating
- heartburn
- indigestion
- hemorrhoids
- jaundice
- nausea or vomiting
- pain with swallowing
- poor appetite
- rectal bleeding
- rectal pain
- regurgitation of food
- soiling/incontinence
- vomiting blood

Cardiovascular

- chest pain or tightness
- rapid or irregular heart beat
- shortness of breath
- swelling of legs
- varicose veins

Respiratory

- chronic cough
- wheezing
- shortness of breath
- need for oxygen therapy

Urinary

- pain or difficulty with urination
- frequent urination
- blood in urine
- incontinence of urine

Musculoskeletal

- stiff or painful joints
- swollen joints
- back pain
- muscle pain

Hematologic

- frequent bruising
- bleeding doesn't stop easily

Endocrine

- heat or cold intolerance
- excessive thirst or urination
- steroid therapy (prednisone)

Genitoreproductive - Male

- discharge from penis
- testicular pain or lump

Genitoreproductive - Female

- heavy periods
- date of last period: _____

Dermatologic

- rash or hives
- itching
- tattoos

Neurologic

- numbness or tingling
- dizziness or lightheadedness
- vertigo
- headaches
- weakness in arms or legs
- blurred vision
- difficulty with memory

Psychiatric

- anxiety
- depression
- panic attacks
- tired on waking up in morning

Immunizations

- Hepatitis A
- Hepatitis B

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or *who* may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the service provided and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Alabama Digestive Diseases, P.C. For example, information on the services you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use of disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use of information that occurred before you notified us of your decision.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

Contact Person

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205-481-7384

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This notice is effective on or after April 14, 2003

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use of Disclosure of Your Information

You may request a restriction on the use of disclosure of your protected health information.

Alabama Digestive Diseases, P.C. may or may not agree to restrict the use of disclosure of your protected health information.

If Alabama Digestive Diseases, P.C. agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use of disclosure that has already occurred prior to the date on which you revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

Alabama Digestive Diseases, P.C. reserves the right to modify the privacy practices outlined in the notice.

Signature

I have reviewed this consent form and give my permission to Alabama Digestive Diseases, P.C. to use and disclose my health information in accordance with it.

Name of Patient (Print or Type)

Signature of Patient

Date

Signature of Patient Representative

Relationship of Patient Representative to Patient