Gastroenterology Consultants of the North Shore, S.C.

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Appt Date: _____ Time: _____ Evanston Hospital Glenbrook Hospital Office

CONFIDENTIAL PATIENT INFORMATION

NAME (LAST, FIRST)		SOCIAL SECURITY #		DATE OF BIRTH	SEX M F	AGE	EMAIL
STREET ADDRESS	CITY	STATE	ZIP	CELL PHONE			HOME PHONE
PATIENT EMPLOYER		EMPLOYER'S ADDRESS					BUSINESS PHONE
PRIMARY INSURANCE NAME:	☐ PPO ☐ HMO	ID:		GROUP:			PRIMARY INS PHONE:
SUBSCRIBERS NAME (IF NOT PATIENT)		SOCIAL SECURITY #		RELATIONSHIP	SEX M F		DATE OF BIRTH
SECONDARY INSURANCE NAME:	☐ PPO ☐ HMO	ID:		GROUP:			SECONDARY INS PHONE:
SUBSCRIBERS NAME (IF NOT PATIENT)		SOCIAL SECURITY #		RELATIONSHIP	SEX M F		DATE OF BIRTH
PRIMARY CARE DOCTOR		PHONE:					FAX:
ADDRESS	CITY		STATE	ZIP			REFFERED BY:
PHARMACY PHONE:	PHARMACY FAX:		PHARMACY NAME & ADDRESS:				

INSURANCE AUTHORIZATION AND ASSIGNMENT

1) All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance payments. However, the patient is ultimately responsible for all fees, regardless of insurance coverage. For patients without insurance, it is necessary to make arrangements in advance with our account representative.
2) The patient authorizes and requests the insurance company to pay directly to GCNS insurance benefits otherwise payable to them.
3) The patient authorizes the release of any information including the diagnosis and the records of any treatment or examination rendered to them during the period of such care to third party payors and/or other health care practitioners.

MEDICARE PATIENT ACKNOWLEDGEMENT OF NON-COVERED SERVICES INCLUDING ADMINISTRATIVE FEES. The practice does not accept Medicare assignment.

If the patient receives notification that Medicare denied payment for services ordered by the physician according to section 1862(a)(1) of the Medicare Law, he or she agrees to be personally and fully responsible for the payment. The patient understands that if any part of the claim is denied, he or she will receive a bill from GCNS.

I acknowledge that I have been given an opportunity to review a copy of Gastroenterology Consultants of the North Shore's patient's privacy policy.

I hereby authorize the release of records to and from GCNS, S.C. and my primary doctor with any information including the diagnosis and records of any treatment or examination rendered to me.

Patient Signature	Date

(CONTINUED)

Patient Name: _____ **Date of birth:** _____

Please list any Allergies: _____

Please list all prescription and over the counter medications you take below (including vitamins/supplements). If you need more room, please bring us a list.

Medication	Dosage	Frequency	Reason

What is the reason for your current evaluation? _____

_____

Please list any surgeries: _____

_____

Have you ever smoked? _____ **Have you quit?** _____

Do you drink alcohol? _____ **How much?** _____

Is there family history of digestive disease (colon cancer, polyps, colitis, ulcers, gallbladder disease, etc.)?

_____

Please mark any of the following symptoms and please elaborate:

□ Constitutional (fever, weight loss, fatigue): _____
□ Eyes (change in vision, redness, discharge): _____
□ Ear/Nose/Throat: (sinusitis, hoarseness, change in voice): _____
□ Cardiovascular (chest pain, palpitations, poor circulation): _____
□ Respiratory (shortness of breath, wheezing, cough): _____
□ Hematologic (anemia, bleeding, bruising): _____
□ Endocrine (thyroid, osteoporosis, diabetes): _____
□ Gastrointestinal (diarrhea, constipation, abdominal pain): _____
□ Skin (rash, itching, change in color): _____
□ Genitourinary (discharge, pain, rash): _____
□ Musculoskeletal (weakness, muscle aches, joint aches): _____
□ Neurologic (stroke, seizure, weakness): _____
□ Psychiatric (depression, anxiety, hallucination): _____
□ **None of the above**

(GCNS only) PHYSICIAN Signature: _____ Date: _____