

Appointment _____

PLEASE COMPLETE, SIGN AND RETURN IN THE ENCLOSED ENVELOPE AS SOON AS POSSIBLE. PLEASE BRING INSURANCE CARD.



Portland Gastroenterology CENTER

- JOHN F. ERKKINEN, M.D.
- DOUGLAS A. HOWELL, M.D.
- ALAN E. KILBY, M.D.
- ANDREAS M. STEFAN, M.D.
- THALIA MAYES, M.D.
- BENJAMIN B. POTTER, M.D.
- MICHAEL A. ROY, M.D.
- G. ALEX MILLSPAUGH, M.D.
- JAMES H. MORSE, M.D.
- JOHN J. BOSCO, M.D.

Date _____ Sex _____ Marital status _____

Patient # _____ PCP _____

Last name _____ Referring doctor _____

First name _____ Initial _____ Social security # _____

Address _____ Employer _____

City _____ State _____ Address _____

Zip code _____ City _____ State _____

Home phone _____ Zip code _____

Date of birth _____ Age _____ Business phone _____

Email address _____ Extension _____

Who to contact in case of emergency _____ Relationship _____

Home phone _____ Business phone _____

INSURANCE INFORMATION

Screening Colonoscopies may or may not be covered. PLEASE CHECK WITH YOUR INSURANCE COMPANY.

Name of Subscriber _____

Name & address of Primary Insurance _____

Certificate # _____ Group # _____ Co-Pay \$ _____

Name & address of Secondary Insurance _____

Certificate # _____ Group # _____

CONTINUING PAYMENT AUTHORIZATION

I hereby assign benefits to the physician or facility indicated on the claim.

Signed _____ Date _____

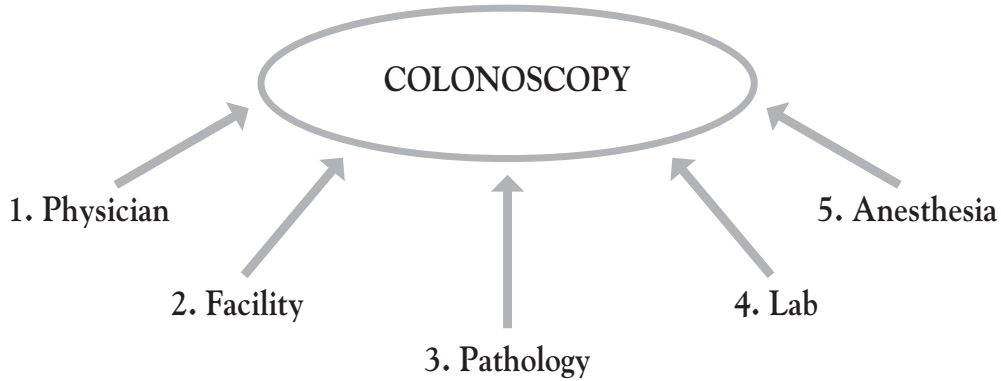
PLEASE REVIEW AND SIGN ON REVERSE SIDE →

UNDERSTANDING PROCEDURE BILLING

Every procedure that is performed includes up to 5 components. Each of these components bill for their services separately. You may not have all 5 components depending on your situation, but you will always have at least 2.

A physician fee and a facility fee are always charged regardless of where the procedure is done.

Here is an example of a colonoscopy performed at Portland Endoscopy Center where a biopsy is taken, and the patient opted for Propofol anesthesia. This patient will receive 5 separate bills.



BILLING POLICY

The following is the general billing policy of **Portland Gastroenterology Center (PGC)**. Please review this information and sign where indicated.

- I understand that it is my responsibility to provide PGC with current, accurate billing information at the time of check in and to notify PGC of any changes in this information.
- I understand that it is my responsibility to know my specialist co-pay and to pay it prior to services being rendered.
- I understand that I will be billed for any amounts due by me (co-pay, coinsurance, and deductibles) and that I have a financial responsibility to pay these amounts. I further understand that I am responsible for any bills not paid by my insurance carrier.
- I understand that if I do not pay, my account balance may be forwarded to an outside collection agency.
- I understand that if I do not provide 3 business days notice when canceling an appointment I may be charged a no-show fee.

My signature below confirms that I have read these billing policies.

Signed _____ Date _____

Name _____

Date of Birth _____ Age _____

E-mail _____

Cell Phone _____

Chief Complaint (Reason for visit)

Allergies

(List all medicines you are allergic to and what kind of reaction you experienced)

Physicians you would like to receive a copy of your report:

Medical Problems/Illnesses/Hospitalizations

Family Medical History

Anyone in your immediate family been diagnosed with:

Condition	Relation	Age Diagnosed
High Blood Pressure	_____	_____
Polyps	_____	_____
Diabetes	_____	_____
Heart disease	_____	_____
Liver Disease	_____	_____
Colon cancer	_____	_____
Inflammatory bowel	_____	_____
Colitis	_____	_____
Irritable bowel syndrome	_____	_____
Crohn's	_____	_____
Other GI problems	_____	_____

Surgeries (List operations and approximate year)

Colonoscopies/Upper Endoscopies (List procedures and approximate year)

Do you have an ICD/Defibrillator? _____

Do you take blood thinners? _____

Are you pregnant? _____

Medicines

List of current medications you are now taking:

Name	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Social History

Occupation _____

Marital Status _____ Children? _____

If yes, number and their ages

Alcohol? No Yes _____ amt/week

Smoking? No Yes _____ packs/day

For _____ years

Quit _____ how many years ago?

FOR OFFICE USE ONLY:

Wt. _____ BP _____ P _____

Ht. _____ T _____

(Please see Page 3)

Name _____ Date of Birth _____

REVIEW OF SYSTEMS

Constitutional

- Recent weight change No Yes
- Fever No Yes
- Fatigue No Yes
- Night sweats No Yes

Eyes

- Recent change in vision No Yes
- Glaucoma No Yes

Ears/Nose/Mouth/Throat

- Hearing loss No Yes
- Ringing in ears No Yes
- Mouth sores No Yes

Cardiovascular

- Chest pain No Yes
- Shortness of breath No Yes
- Swelling of ankles No Yes
- I.C.D./Defibrillator No Yes
- Pacemaker No Yes
- Heart valve No Yes

Respiratory

- Chronic cough No Yes
- Spitting up blood No Yes
- Wheezing No Yes

Genitourinary

- Burning with urination No Yes
- Blood in urine No Yes

Musculoskeletal

- Joint pain or swelling No Yes
- Back pain No Yes
- Muscle pain No Yes

Skin

- Rash No Yes
- Itching No Yes

Gastrointestinal

- Poor appetite No Yes
- Difficulty swallowing No Yes
- Heartburn No Yes
- Nausea or vomiting No Yes
- Bloating No Yes
- Belching No Yes
- Regurgitation No Yes
- Constipation No Yes
- Diarrhea No Yes
- Abdominal pain No Yes
- Change in bowel habits No Yes
- Rectal bleeding No Yes
- Black, tarry stools No Yes

Neurological

- Headaches No Yes
- Seizures No Yes
- Strokes No Yes
- Numbness No Yes

Psychological

- Anxiety No Yes
- Depression No Yes

Endocrine

- Heat/cold intolerance No Yes
- Excessive thirst or urination No Yes

Hematological

- Easy bleeding/bruising No Yes
- Anemia No Yes
- Do you take blood thinners? No Yes
- Do you use aspirin? No Yes

Transfusions

- Past blood transfusion No Yes

Female Only

- Are you pregnant? No Yes
- Heavy periods No Yes
- Abnormal vaginal bleeding No Yes

Do not write below this line.
