OPEN ACCESS PAPERWORK

Please complete the enclosed paperwork and return to our office as soon as completed.

We require a copy of your health insurance card (front and back), insurance referral (if your insurance plan requires one), and driver's license to be enclosed with the paperwork.

Once the required paperwork is returned to our office and we receive the required information from your primary care physician, we will call you to schedule the procedure. Also at that time, we will mail to you the preparation instructions and forms necessary for the facility where you will be having your procedure.

If you have any questions regarding this, please call our office at 401-943-1300 for the Cranston office or 401-789-1860 for the Narragansett office

Thank you, Gastrointestinal Medicine Associates, Inc.

Request for Open Access Colonoscopy

Please fill out the following information AND provide a copy of your insurance card and driver's license and mail to our office.

NAME:_____D.O.B.:_____ Age:_____

Height:_____ Weight:_____

Primary Care Physician: _____

Date of Last Office Visit: _____

Reason for colonoscopy: ____Screening – 50 or older

____Family history of colon cancer or precancerous polyp
Which relative? _____

_____Previous colonoscopy showing polyps

Date of prior exam, physician and name of facility _____
_____Prior history of colitis?

MEDICATIONS AND DOSAGES(Please list all prescription and over the counter medications you currently take). A separate sheet is enclosed to record these.

Do you take: Aspirin **Yes** **No**
Over the counter pain medication **Yes** **No** If yes, which one: _____
Diabetes medication **Yes** **No** If yes, which one:_____
Plavix, Coumadin or other blood thinners **Yes** **No** If yes, which one:_____

LIST ALL ALLERGIES: _____

----OVER----

 Name:_____

PAST MEDICAL HISTORY (List all chronic medical conditions you have been diagnosed with)

_____ _____

_____ _____

_____ _____

PAST SURGERIES (Please list all prior surgeries)

_____ _____

_____ _____

_____ _____

FAMILY HISTORY

_____ _____

_____ _____

SOCIAL HISTORY (I.E., SMOKING, ALCOHOL, CAFFEINE, DRUGS)

_____ _____

_____ _____

Have you had excessive or prolonged bleeding from previous injury or surgery? YES NO
Do you have any metal implants in your body (i.e., joint replacement)? YES NO
Do you have a pacemaker or cardiac defibrillator? YES NO

Patient Signature_____ **Date**_____

Physician Signature_____ **Date**_____
THIS IS FOR GASTROINTESTINAL MEDICINE ASSOCIATES,INC. USE ONLY

THIS FORM MUST BE RETURNED TO OUR OFFICE AS SOON AS POSSIBLE

PERMISSION TO DISCUSS MEDICAL CARE

DATE:_____

PATIENT NAME:_____

PATIENT DATE OF BIRTH:_____

I,_____, will allow the physicians and staff at Gastrointestinal Medicine Associates, Inc. to discuss any and all issues concerning my medical care with _____ _____

_____

_____

_____

_____

_____

RELATIONSHIP TO PATIENT:_____

NOTE: Unless Gastrointestinal Medicine Associates, Inc. is notified by you in person or by certified mail, the above PERMISSION TO DISCUSS MEDICAL CARE shall remain in effect indefinitely.

When it is necessary to contact you by telephone, i.e. to confirm or cancel an appointment, to give information to you regarding a booking or test that our office has scheduled on your behalf etc., may we call the telephone numbers which you have provided, and if you are not available may we:

_____ leave a message on your answering machine
_____ leave a message with anyone other than yourself
_____ Name of Person or Persons_____
_____
_____ Anyone who answers

Telephone numbers we may call:

_____home
_____work
_____other

Signed:_____
Date:_____ witness:_____

GASTROINTESTINAL MEDICINE ASSOCIATES, INC.
PATIENT INFORMATION SHEET

Patient Name_____

FIRST MIDDLE LAST

Mailing Address_____

Street Address_____

City_____ **State**_____ **Zip**_____

Home Phone #_____ **Cell Phone #**_____ **Work**

Phone #_____ **Date of Birth**_____

Social Security #_____ **Marital Status** _____

Employer_____

E-mail_____

Emergency Contact _____

Relationship to Patient_____ **Phone#**_____

Doctor/Person Referring You_____

Primary Care Physician_____

Pharmacy_____ **Phone #**_____

PLEASE CIRCLE ONE:
Race:
American Indian or Alaska Native
Asian
Native Hawaiian or Other Pacific Islander
Black or African American
White
Hispanic
Other Pacific Islander
Unreported/Refused to Report
Other Race_____

PLEASE CIRCLE ONE:
Ethnicity:
Hispanic or Latin
Not Hispanic or Latin
Refused to Report

Primary Language:_____

MEDICAL INSURANCE COVERAGE INFORMATION—PAGE 2

Primary Insurance Carrier_____
Primary Insurance ID/Member #_____
Primary Insurance Group #_____
Subscriber Name_____ **Date of Birth**_____

Secondary Insurance Carrier_____
Secondary Insurance ID/Member #_____
Secondary Insurance Group #_____
Subscriber Name_____ **Date of Birth**_____

Tertiary Insurance Carrier_____
Tertiary Insurance ID/Member #_____
Tertiary Insurance Group #_____
Subscriber Name_____ **Date of Birth**_____

PATIENTS WITH HEALTH INSURANCE

I hereby authorize Gastrointestinal Medicine Associates, Inc., to release information to my insurance carrier(s) regarding my medical services and treatment in order to file a claim. I hereby assign all payments for medical services rendered to myself and dependents. I understand that I am financially liable for any co-pays, cost share, deductible, or co-insurance rendered to myself or dependents. I am responsible to pay within 30 days of my first bill or I will be subject to a 1.5% interest charge per month. If it becomes necessary to file suit to collect this bill, I agree to pay court costs and reasonable attorney fees to the extent permitted by law. A copy of this signature is valid as the original.

SIGNATURE:_____**DATE:**_____

PATIENTS WITHOUT HEALTH INSURANCE

I understand that I am financially responsible for any and all services rendered to me by Gastrointestinal Medicine Associates, Inc. Payment is due at the time of service unless other arrangements have been made. I am responsible to pay within 30 days of my first bill or I will be subject to a 1.5% interest charge per month. If it becomes necessary to file suit to collect this bill, I agree to pay court costs and reasonable attorney fees to the extent permitted by law. A copy of this signature is valid as the original.

SIGNATURE:_____**DATE:**_____

MEDICATION YOU ARE CURRENTLY TAKING INCLUDING VITAMINS

Name:_____ Date of Birth:_____ Date:_____

Allergies:_____

Pharmacy Name:_____ Location:_____

Medication Name	Strength	Directions for Use	Prescribing Provider

IMPORTANT!!

PATIENT PORTAL FOR GASTROINTESTINAL MEDICINE ASSOCIATES, INC.

Once we have obtained your email address, you will receive an email with your username and temporary password to access our Portal along with the url below.

We ask that you log onto the Patient Portal and send us a message indicating a successful connection. This is the web address:
https://mycw54.eclinicalweb.com/portal6362/jsp/100mp/login.jsp

The Patient Portal provides you with secure access to your:

- Vitals
- Diagnoses
- Upcoming Appointments
- Etc.

The Patient Portal is for non-urgent communications only! If you have an emergency needing clinical care, please dial 911.

This site is for your convenience and information purposes only and is not intended to treat or diagnose conditions. You can request refills, appointments, and ask questions.

Please allow 24 hours for a response to messages left on this site.