Florida Digestive Specialists

Gastroenterology and Liver Disease Management
Over 30 Years of Service

5651 49th Street North,
St. Petersburg, FL 33709
Phone: (727) 443-4299

1417 S. Belcher Road, Suite A
Clearwater, FL 33764
Fax: (727) 443-0255

Welcome to Florida Digestive Specialists, P.A.

Please read and sign our office policy regarding insurance and billing.

We are preferred providers for many insurance companies. Please check with our office or consult your insurance handbook if you have questions. We will be happy to file with your insurance on your behalf. You will be responsible for all deductibles, copays, coinsurances at the time of service, in addition to any non-covered services.

We accept Medicare assignment and many HMOs. If you are a member of an HMO, you must obtain prior authorization for all services through your primary care physician.

Patients without insurance coverage are expected to pay in full at the time of service, unless prior arrangements have been made with our office.

All charges not paid by your insurance company are your responsibility.

Please advise our office whenever you have a change of address, phone number or insurance coverage.

- **If your procedure is not canceled at least 72 hours in advance you will be charged a seventy five dollar ($75.00) fee; this will not be covered by your insurance company.**

If you miss 4 appointments without cancelling or no show, it will require us to consider discharging you from the practice

All patients must present a current photo ID or Driver's License, if you do not have one or one is not on file we will not be able to see you for your scheduled appointment.

I have read and fully understand the above financial policy.

Patients Name: _____ DOB: _____

Patients Signature: _____ Date: _____

Jay K. Kamath, M.D.
Gastroenterologist

Sally Follett, ARNP-C
Nurse Practitioner

Lina Hernandez, ARNP-C
Nurse Practitioner

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I HEREBY AUTHORIZE
to release information from my medical records, including information of a psychological, psychiatric and alcohol or drug-related nature, HIV/AIDS:

To: _____

From: _____

Date of Hospitalization: _____

Patient's Printed Name: _____ DOB: _____

Patient's Signature: _____

Information Requested

( ) Discharge Summary
( ) Operation Report(s)
( ) X-ray Report(s) & Film(s)
( ) Psychological Records
( ) Alcohol/Drug Related
( ) Office Visit(s)
( ) Other

( ) History & Physical
( ) Pathology Report(s)
( ) Laboratory Report(s)
( ) Psychiatric Record (s)
( ) AIDS/HIV Records
( ) All of the above

DATED: This _____ Day of _____

Witness: _____ Patient: _____

Witness: _____ Relative _____
or Legal Guardian

*Authorization must be signed by the patient, or by the parents if patient is a minor; or by nearest relative or Court-Appointed Guardian if patient is physically or mentally incompetent

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CONFIDENTIALITY QUESTIONNAIRE

PLEASE PRINT the family members or other persons, if any, whom we may inform about your **general medical condition and your diagnosis** (including treatment, payment and health care options).

Name: _____ Relationship: _____

Home # (____) _____ Cell # (____) _____ Work # (____) _____

Name: _____ Relationship: _____

Home # (____) _____ Cell # (____) _____ Work # (____) _____

Please list the family member or significant other, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY**.

Name: _____ Relationship: _____

Home # (____) _____ Cell # (____) _____ Work # (____) _____

Name: _____ Relationship: _____

Home # (____) _____ Cell # (____) _____ Work # (____) _____

May we leave a message on your answering machine/voice mail regarding your results or health care information? Yes No

Please note that in an emergency or for the purpose of your care and when the medical information is directly relevant to that person's involvement with your care, we may disclose your medical information to family members, other relatives or close personal friends other than the above listed.

PATIENT NAME (please print): _____ DOB: _____

Patient/Representative Signature: _____ Date: _____

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Patient Name: _____ DOB: _____ Date: _____

Please circle Yes or No in answer to the following medical history questions.
Do you have any allergies to medications, eggs and or Latex? YES / NO

Please list any allergies: _____

Please list any previous surgery:

Type of surgery	**Year**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

If you have had seizures, please provide the date of your most recent seizure:_____

YES / NO Problems with: sedation/anesthesia, opening your mouth, breathing tubes?
YES / NO Are you on Coumadin/(Warfarin Sodium), iron supplements (incl. vitamins), Lovenox, Plavix, Xarelto?
YES / NO Had chest pain (angina) or breathing problems ?
YES / NO Had a heart attack or stroke in the last 6 months?
YES / NO Personal history of Congestive Heart Failure (CHF), renal failure/insufficiency?
YES / NO Do you have a defibrillator/pacemaker or combination of both?
YES / NO Had heart valve surgery?
YES / NO Had a coronary/vascular stent within the last year?
YES / NO Had kidney failure?
YES / NO Had intestinal surgery within the last 3 months?
YES / NO On Oxygen or CPAP?
YES / NO Currently infected with HIV or TB?
YES / NO Do you have chronic heartburn? (2 times or more per week)
YES / NO On chronic narcotic pain medicines? If so, how often? _____
YES / NO Been hospitalized in the last month? If so, where _____ when _____
YES / NO Have you had an upper endoscopy in the past 30 days? If so, where _____ when _____
YES / NO Had a colonoscopy previously? When? _____ Where? _____
YES / NO Do you have relatives with colon cancer/colon polyps? If so, who? _____ What? _____

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Review of Systems

General/Constitutional:

Appetite Reduced	O Yes	O No
Fatigue	O Yes	O No
Fever	O Yes	O No
Night Sweats	O Yes	O No
Weight Gain	O Yes	O No
Weight Loss	O Yes	O No

HEENT/Neck:

Change in Vision	O Yes	O No
Loss of Hearing	O Yes	O No
Hoarseness	O Yes	O No
Mouth Sores	O Yes	O No
Sore Throat	O Yes	O No
Swollen Lymph Nodes	O Yes	O No

Endocrine:

Excessive Thirst	O Yes	O No
Diabetes	O Yes	O No
Thyroid Problems	O Yes	O No

Respiratory:

Asthma	O Yes	O No
COPD/OSA (use of C-PAP machine)	O Yes	O No
Cough	O Yes	O No
Coughing up blood	O Yes	O No
Shortness of Breath	O Yes	O No
Wheezing	O Yes	O No

Cardiovascular:

Chest Pain	O Yes	O No
Palpitations	O Yes	O No
PND (shortness of breath during sleep)	O Yes	O No

Gastrointestinal:

Abdominal Pain	O Yes	O No
Black Stools	O Yes	O No
Bloating	O Yes	O No
Change in Bowel Habits	O Yes	O No
Constipation	O Yes	O No
Diarrhea	O Yes	O No
Pain with swallowing	O Yes	O No
Feels full fast after eating	O Yes	O No
Heartburn	O Yes	O No
Uncontrolled Bowel Habits	O Yes	O No
Nausea	O Yes	O No
Pain when Swallowing	O Yes	O No
Rectal Bleeding	O Yes	O No
Vomiting	O Yes	O No

Hematology:

History of Blood Transfusion	O Yes	O No
Abnormal Bleeding	O Yes	O No
Anemia	O Yes	O No
Easy Bruising	O Yes	O No

Genitourinary:

Passing Stool/Gas from Vagina	O Yes	O No
Blood in Urine	O Yes	O No
Pain with Urination	O Yes	O No
Urinary Incontinence	O Yes	O No
Vaginal Bleeding	O Yes	O No

Musculoskeletal:

Joint Swelling	O Yes	O No
Arthritis	O Yes	O No
Bone Pain	O Yes	O No
Muscle Aches	O Yes	O No

Dermatologic:

Itching	O Yes	O No
Jaundice (yellowing of skin and/or eyes)	O Yes	O No
Rash	O Yes	O No
Skin Cancer	O Yes	O No

Neurologic:

Loss of Strength/Sensation	O Yes	O No
Confusion	O Yes	O No
Dizziness	O Yes	O No
Headache	O Yes	O No
Seizures	O Yes	O No
Strokes	O Yes	O No
Tingling/Numbness	O Yes	O No

Psychiatric:

Anxiety	O Yes	O No
Depression	O Yes	O No
Eating Disorder	O Yes	O No

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Social History

Date: _____

Patient Name: _____ DOB: _____

These questions are only intended to assist in your healthcare. **Please circle or check:**

Do you smoke cigarettes? No Yes

Do you drink alcohol currently? No Yes

If yes, how much do you drink? (1 serving=12oz beer, 5oz wine or 1.5oz liquor) please check:

____ Occasional use-less than 3 servings per month

____ Less than 7 servings per week

____ More than 2 servings per day

____ More than 7 servings per week

If these do not apply, please indicate other amount:
_____ Servings per _____

The following questions refer to <u>recreational</u> drug use:

Have you **ever** snorted drugs (intranasal)? No Yes

Have you **ever** used intravenous (IV) drugs? No Yes

Have you used any drugs other than what's prescribed to you in the past 6 months?
No Yes

If yes, what did you use? _____

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MEDICATIONS

MEDICATION	DOSE	HOW OFTEN	WHAT FOR

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