Charleston Gastroenterology Specialists
Charleston Endoscopy Center
Summerville Endoscopy Center

1962 Charlie Hall Blvd
Charleston, SC 29414
Phone (843) 722-8000
Fax (843) 723-7850

Patient Interview Form

Patient Information

First Name:________________ Last Name:________________

MRN:________________ Date Of Birth:________________

Age:________________ Notes:________________

Email

Please check one as your preferred email for communications

- ☐ Personal:________________
- ☐ Work:________________

Race

Select one or more

- ☐ White
- ☐ Black or African American
- ☐ Asian
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Unknown
- ☐ Patient declines to specify
- ☐ Prohibited by state law

Ethnicity

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Patient declines to specify
- ☐ Prohibited by state law

Sex

- ☐ Male
- ☐ Female
- ☐ Other

Preferred Language

- ☐ English
- ☐ Patient declines to specify

Contact Preference

- ☐ Email
- ☐ Home phone
- ☐ Home or cell phone
- ☐ Cell Phone
- ☐ Patient declines to specify

Consent to Share Data

I consent to having my medical and demographic information shared with other health care entities.

- ☐ Yes
- ☐ No

Reminder Preference

I would like to receive preventive care and follow up care reminders.

- Yes
- No

Allergies

- Patient has no known allergies
- Patient has no known drug allergies
- Latex
- Adhesive Tape
- Iv Dye, Iiodine containing
- Shellfish
- erythromycin (bulk)
- Penicillins
- Sulfa (Sulfonamide Antibiotics)
- Demerol
- propofol
- morphine
- fentanyl
- midazolam
- codeine sulfate
- Nickel sensitivity
- Soy
- Eggs

Pharmacy

Name ____ Address ____ Phone ____

Consent to Import Medication History

I consent to obtaining a history of my medications purchased at pharmacies.

- Yes
- No

Current Medications

- None

Immunizations

- None
- Flu vaccine When:____________
- Hep A When:____________
- Hep B When:____________
- Pneumovax When:____________
- PPD When:____________

Diagnostic Studies/Tests

- None
- CT Abdomen When:____________
- Abdominal Ultrasound When:____________
- MRI Abdomen/Pelvis When:____________
- Gastric Emptying Study When:____________
- Barium Swallow When:____________
- EGD When:____________
- Colonoscopy When:____________
- ERCP When:____________
- Lab work When:____________

Previous Procedures

- None
- Pacemaker Insertion Manufacture: Serial Note: When:____________
- Defibrillator Placement Manufacture: Serial #: Note: When:____________
- Bilateral Tubal Ligation (BTL) When:____________
- Hysterectomy When:____________
- C-Section When:____________
- Abdominal Surgery When:____________
- Cholecystectomy When:____________
- Appendectomy When:____________
- Hernia repair When:____________
- Bowel resection When:____________
- Gastric Bypass When:____________
- Gastric Lap Band (banded gastroplasty) When:____________
- Colon resection When:____________
- Hemorrhoidectomy When:____________
- Hemorrhoid banding When:____________
- Exploratory Laparoscopy When:____________
- Bladder Surgery When:____________
- Mastectomy When:____________
- Back surgery When:____________
- Joint Replacement (in the last year) When:____________
- Abdominal aortic aneurysm (AAA) repair When:____________
- Coronary Artery Bypass Graft (CABG) When:____________
- Cardiac Cath - with stent placement When:____________

Social History

Marital Status

- Single
- Married
- Divorced
- Separated
- Widowed
- Civil Union
- Unknown
- Other

Alcohol

- None
- Weekends only
- 1 drink per day
- 2 drinks per day
- occasional
- 1 drink per week
- 2-3 drinks per week
- 3-4 drinks per week

Tobacco

Smoking Status

- Current every day smoker
- Current some day smoker
- Former smoker
- Never smoker
- Smoker, current status unknown
- Light tobacco smoker
- Heavy tobacco smoker
- Unknown if ever smoked

Type	Quit	Quantity	Frequency
Cigarettes			
Chewing Tobacco			

Drug Use

- None
- Marijuana
- Cocaine
- Heroin
- Other

Family Medical History

- No knowledge of family history

No family history of

- Colon Cancer
- Colon Polyps

Father Mother Sister Brother Son Daughter

Diagnoses

Colon CA, Family History ○ ○ ○ ○ ○ ○
Colon Polyps, Family History ○ ○ ○ ○ ○ ○
Stomach Cancer ○ ○ ○ ○ ○ ○
Celiac disease ○ ○ ○ ○ ○ ○
Pancreatic Cancer ○ ○ ○ ○ ○ ○
Liver disease ○ ○ ○ ○ ○ ○
Ulcerative colitis ○ ○ ○ ○ ○ ○
Inflammatory bowel disease ○ ○ ○ ○ ○ ○
Crohn's disease ○ ○ ○ ○ ○ ○

Past or Present Medical Conditions

- None

Category				
Heart Disease	High blood pressure	Myocardial infarction	Congestive Heart Failure	Atrial Fibrillation
	Hyperlipidemia	CAD	Mitral Valve Prolapse	
Lung Disease	Asthma	Wheezing	Emphysema	Sleep Apnea
	COPD	Home Oxygen Therapy	Blood Clot (Lungs)	
Neurological Disorders	Stroke	Seizures	Migraine Headaches	Spinal Nerve Stimulator
	TIAs			
Blood/Clotting Disorders	Anemia	Thrombocytopenia	Blood Thinners	
Gastrointestinal Disorders	Reflux	Gastric Ulcers	Barrett's	Gastric Polyps
	Crohn's Disease	Ulcerative Colitis	H/O Diverticulitis	Colon Polyps
	Irritable bowel syndrome	Celiac disease	Bowel Obstruction	Pancreatitis
	Cirrhosis			
Diabetes	Insulin Dependent Diabetes Mellitus	Non-Insulin Dependent Diabetes Mellitus	Diet Controlled Diabetes Mellitus	
Cancer	Colon Cancer	Esophageal Cancer	Gastric Cancer	Pancreatic Cancer
	Liver Cancer	Lung Cancer	Breast Cancer	Ovarian Cancer
	Skin Cancer	Prostate Cancer		
Infectious Diseases	Hepatitis B	Hepatitis C	HIV	Shingles
	Chicken Pox	MRSA	VRE	
Other	Personal History Malignant Hyperthermia	Family History Malignant Hyperthermia	Glaucoma	Hypothyroidism
	Fibromyalgia	Anxiety disorder	Depression	Bipolar Disorder
	Arthritis	Kidney Disease		
Pregnancy	Pregnancy: No - Neg urine HCG	Pregnancy: No - Hysterectomy	Pregnancy: No- Post Menopause	Pregnancy: Yes - Positive HCG
	Pregnancy: No- Tubal ligation	Pregnancy: Pt refused urine HCG; denies possibility of pregnancy	Prenancy - No - LMP within the last 28 days	
TB Screen	No signs or symptoms of TB	Fever	Night Sweats	Unexplained Wt Loss
	Persistent Cough >2 wks			

Review Of Systems

Cardiovascular

	Y	N
⬭ None		
chest pain	◯	◯
palpitations	◯	◯
arm / leg swelling	◯	◯

Constitutional

	Y	N
⬭ None		
fatigue	◯	◯
fever	◯	◯
loss of appetite	◯	◯
weight gain	◯	◯
weight loss	◯	◯
chills	◯	◯

ENMT

	Y	N
⬭ None		
difficulty swallowing	◯	◯
ear pain	◯	◯
nose bleeds	◯	◯
sore throat	◯	◯
hearing loss	◯	◯
ringing	◯	◯

Endocrine

	Y	N
⬭ None		
excessive thirst	◯	◯
heat intolerance	◯	◯
cold intolerance	◯	◯
profuse sweating	◯	◯

Eyes

	Y	N
⬭ None		
pain	◯	◯
redness	◯	◯
vision change	◯	◯

Gastrointestinal

	Y	N
⬭ None		
abdominal pain	◯	◯
constipation	◯	◯
diarrhea	◯	◯
black, tary stools	◯	◯
heartburn	◯	◯
nausea	◯	◯
rectal bleeding	◯	◯
vomiting	◯	◯
difficulty swallowing	◯	◯
reflux	◯	◯

Genitourinary

	Y	N
⬭ None		
frequent urination	◯	◯
hematuria	◯	◯
urethral discharge or incontinence	◯	◯
burning	◯	◯

Hematologic/Lymphatic

	Y	N
⬭ None		
easy bruising	◯	◯
hematology	◯	◯
ease of bleeding	◯	◯

Integumentary

	Y	N
⬭ None		
itching	◯	◯
rashes	◯	◯
hair or nail changes	◯	◯
lumps	◯	◯

Musculoskeletal

	Y	N
⬭ None		
stiffness	◯	◯
neck pain	◯	◯
lumps on neck	◯	◯
calf pain	◯	◯
leg cramping	◯	◯

Neurological

	Y	N
⬭ None		
dizziness	◯	◯
fainting	◯	◯
frequent headaches	◯	◯
numbness or tingling	◯	◯
seizures	◯	◯
memory loss	◯	◯
head injury	◯	◯

Psychiatric

	Y	N
⬭ None		
depression	◯	◯
nervousness	◯	◯

Respiratory

	Y	N
⬭ None		
cough	◯	◯
shortness of breath with exercise	◯	◯
wheezing	◯	◯
pain with breathing	◯	◯

Reviewed with

⬭ Patient ⬭ Parent ⬭ Guardian ⬭ Not Present

CHARLESTON GI

Charleston Gastroenterology Specialists
Charleston Endoscopy Center
Summerville Endoscopy Center

_______	NEW PATIENT	_______	ESTABLISHED PATIENT				
_______	Jeffrey M. Basile, MD	_______	Neven Hadzijahic, MD	_______	William F. Marsteller IV, MD	_______	Nathan J. Shores, MD
_______	John K. Corless, MD	_______	Eddie L. Irions Jr., MD	_______	Marc D. Noble, MD	_______	R. Sidney G. Smith, MD
_______	Theodore G. Gourdin, MD	_______	Christopher Lawrence, MD	_______	Lee M. Royall, MD		

PERSONAL INFORMATION *(Please Print)*

LEGAL NAME	LAST NAME	FIRST NAME	MIDDLE I.	(NICKNAME)	SEX ☐ M ☐ F	SOCIAL SECURITY #
MAILING ADDRESS	CITY	STATE	ZIP	AGE	DOB	
HOME PHONE	CELL PHONE	☐ SIN ☐ MAR ☐ WID ☐ DIV	REFERRING PHYSICIAN	PRIMARY CARE PHYSICIAN		
EMAIL ADDRESS	PHARMACY NAME	PHARMACY PHONE #				
PATIENT OR PARENT'S EMPLOYER	BUSINESS PHONE NUMBER	OCCUPATION				
SPOUSE'S NAME	SPOUSE'S EMPLOYER	SPOUSE'S S.S.#	SPOUSE'S DOB			
RESPONSIBLE PARTY (if different from patient)	RESPONSIBLE PARTY ADDRESS	RELATIONSHIP TO INSURED ☐ SPOUSE ☐ CHILD ☐ OTHER				
PERSON TO CONTACT IN CASE OF EMERGENCY (Relationship)	CELL PHONE	HOME PHONE	WORK PHONE			

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY	INSURANCE ID #	SECONDARY INSURANCE COMPANY	INSURANCE ID #
GROUP #	POLICYHOLDER NAME	GROUP #	POLICYHOLDER NAME
POLICYHOLDER SOCIAL SECURITY #	POLICYHOLDER D.O.B.	POLICYHOLDER SOCIAL SECURITY #	POLICYHOLDER D.O.B.

Charleston GI uses Roper/St. Francis for laboratory services and AP laboratory for pathology (biopsy) services. If your insurance requires a specific laboratory please specify: ______________________ ***Pathology:*** ______________________

Charleston Gastroenterology Specialists, Charleston Endoscopy Center, and Summerville Endoscopy Center are **NOT** in-network with the following insurance companies: Aetna HMO, GHI of New York, and MUSC Options This means your insurance company may not reimburse for services provided. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

Charleston Endoscopy and Summerville Endoscopy Centers are **NOT** in-network with Blue Choice HCA, Roper St. Francis BCBS (FRA prefix), and Cigna HCA. This means that procedures **MAY NOT** be scheduled and/or performed in our Endoscopy Center(s).

In order to control the cost of billing, we request that co-payments for office visits be paid at each visit. All self-pay patients are required to make payment in full at time of service. Please present your insurance cards and a picture id upon completion. If you do not have a valid insurance card at time of visit you will be responsible to make payment in full at time of service.

Routine services are not covered by most insurance plans. Your insurance plan may not cover your visit today if you do not have a medical complaint or significant problem/abnormality. In the event that services provided are denied as routine, preventive, pre-existing, or non-covered, you will be responsible for the balance

Your signature below verifies that the above information is correct, and that you have received a copy of the practice Financial Policy and the Notice of Privacy Practices.

Your signature below authorizes payment from Medicare, Medicaid and Private Insurance directly to our practice for any service provided by our physicians.

SIGNED____DATE____________________

PATIENT OR PERSONAL REPRESENTATIVE

CHARLESTON GI
Charleston Gastroenterology Specialists
Charleston Endoscopy Center
Summerville Endoscopy Center

Tel: (843) 722-8000 Fax: (843) 723-7850

PATIENT AUTHORIZATION TO DISCLOSE OR OBTAIN PROTECTED HEALTH INFORMATION

Please print all information. Form must be signed and dated. Instructions are available at the patient's request.

Patient Name: ______________________________ Date of Birth: ____________________

☐ I authorize Charleston GI to disclose/release information to:

Practice/Provider: ______________________

Address: ______________________

City, State, Zip: ______________________

Phone: ______________________

Fax: ______________________

☐ I authorize Charleston GI to obtain information from:

Practice/Provider: ______________________

Address: ______________________

City, State, Zip: ______________________

Phone: ______________________

Fax: ______________________

I authorize Charleston GI to discuss my healthcare treatment with:

☐ Spouse (name) ____________________ ☐ Family Member(s) (name) ____________________

☐ Friend (name) ____________________ ☐ Other (name) ____________________

Description of information to be disclosed: I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

☐ Entire patient record, including but not limited to: office notes; lab results; x-rays; hospital, and other physician records; record of HIV and communicable disease testing; record of mental health or substance abuse treatment.

☐ Only disclose the following: ______________________________

Purpose of disclosure (please check the purpose of the disclosure or check patient request):

☐ Patient Request ☐ Continued Care ☐ Other (please specify): ______________________________

This authorization will expire one year from the date of your signature below, unless you specify an earlier termination. You must submit a new authorization after the expiration date to continue the authorization.

As stated in our Notice of Privacy Practices, you have the right to terminate this authorization by submitting a written request to our Privacy Manager.

The practice places no condition to sign this authorization on the delivery of healthcare or treatment.

We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information, once disclosed under this authorization, will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

______________________________ ____________________
Patient or Representative Signature Date

______________________________ ____________________
Patient or Representative Signature Date

______________________________ ____________________
Patient or Representative Signature Date

Copies of signed authorizations are available upon request.

CHARLESTON GI
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Patient Authorized Method of Communication for Disclosure of Protected Health Information

Form 7.34

Please print all information, then sign and date authorization form at the bottom.

Patient Name: ____ **Date of Birth:** ____________________

Purpose of Authorization – It is the policy of this practice to provide communication with patients, as stated in our Notice of Privacy Practices, *"by phone or other means designated by you to provide results from exams and tests and to provide information that describes or recommends alternatives regarding your care."* The practice requires the following authorization for release of protected health information (PHI) via alternative means (other than the primary home phone number that you have provided).

I authorize the practice to disclose or provide PHI to me as described below. I understand that it is my responsibility to notify the practice of any change in this manner of communication and that any disclosure made to the designated address or number, indicated by me, is subject to the re disclosure statement within this authorization.

☐ Cell phone: ☐ US Mail: ☐ Work phone: ☐ Text: (for appointment reminders only)

____

Description of information to be disclosed - I authorize the practice to disclose the following PHI about me:

☐ Okay to leave call back phone number only ☐ Okay to leave detailed message on answering machine/voice mail

Purpose of disclosure: I am authorizing the alternative means of communication for disclosure of my PHI to ensure the confidentiality of communications from the practice.

Expirations or termination of authorization: This authorization will renew automatically, unless I specify an earlier termination. If I specify an expiration date, I understand that I must submit a new authorization to continue the authorization after that date.

(Please list desired expiration date or leave blank):____

Right to revoke or terminate: As stated in the practice's Notice of Privacy Practices, I have the right to revoke or terminate this authorization at any time. This can be done in person or by mailing a written request to the practice, Attn: Privacy Manager, 1962 Charlie Hall Boulevard, Charleston, SC 29414.

Non-Conditioning Statement: The practice places no condition to sign this authorization on its delivery of healthcare or treatment.

Re disclosure Statement: I understand that the practice has no control regarding persons who may have access to the mailing address, telephone, or cell number I have designated to receive my PHI. Therefore, I understand that my PHI disclosed under this authorization will no longer be the responsibility of this practice.

Secure Communication: Note that regular email is not secure, and it is possible for your PHI to be compromised during transmission to, or from our practice, therefore, we do not email PHI.

____ ________________________

Patient Signature Date

Copies of signed authorizations are available upon request.