Frontier Gastroenterology Center

Date__________ PATIENT NO.__________

PATIENT INFORMATION – INFORMACION DE PACIENTE

PATIENT INFORMATION

PATIENT NAME (LAT, FIRST, MI) – NOMBRE DE PATIENTE (APELLIDO,NOMBRE,MI)				SSN – SEGURO SOCIAL
HOME NUMBER – TELEFONO	SEX - SEXO	DOB – FECHA DE NACIMIENTO	AGE - EDAD	MARTIAL STATUS – ESTADO MATRIMONIAL
ADDRESS – DIRECCION				APT/SPACE/UNIT#
CITY – CIUDAD		STATE – ESTADO		ZIP – ZONA POSTAL
RACE- RAZA __ African American __ American Indian __ Asian Pacific Islander White		ETHNICITY- ETNICO Latino Non-Latino		LANGUAGE- LENGUAJE
PATIENT'S EMPLOYER – NOMBRE DEL EMPLEADOR		OCCUPATION – OCUPACION		
EMPLOYER'S ADDRESS – DIRECCION DEL EMPLEADOR				TELEPHONE – TELEFONO
CITY – CIUDAD		STATE – ESTADO		ZIP – ZONA POSTAL

ER

NOTIFY IN CASE ORF EMERGENCY	PHONE – TELEFONO	RELATIONSHIP – RELACION	
ADDRESS – DIRECCION	CITY - CIUDAD	STATE – ESTADO	ZIP – ZONA POSTAL

RESPONSIBLE PARTY – REPRESENTABLE DE RESPONSIBLE

RESPONSIBLE PARTY

GUARANTOR NAME (LAST, FIRST, MI) – PERSONA RESPONSIBLE		SSN – SEGURO SOCIAL
ADDRESS – DIRECCION		TELEPHONE – TELEFONO
CITY – CIUDAD	STATE – ESTADO	ZIP – ZONA POSTAL
GUARANTOR EMPLOYER – EMPLEADOR	OCCUPATION – OCUPACION	
GUARANTOR EMPLOYER'S ADDRESS – DIRECCION DEL EMPLEADOR		TELEPHONE – TELEFONO
CITY – CIUDAD	STATE – ESTADO	ZIP – ZONA POSTAL

ER

REASON FOR VISIT – RASON POR SU VISITA	REFERRING PHYSICIAN – DOCTOR DE FREFERENCIA	HOW DID YOU HEAR ABOUT OUR OFFICE?

INSURANCE INFORMATION – ASEGURANZA INFORMACION

PRIMARY INS

PRIMARY INSURANCE CO – PRIMARIA ASEGURANZA		TELEPHONE – TELEFONO	
ADDRESS – DIRECCION	CITY – CIUDAD	STATE – ESTADO	ZIP – ZONA POSTAL
POLICY HOLDER'S NAME – NOMBRE DE EL ASEGURADO	DOB – FECHA DE NACIMIENTO		SSN – SEGURO SOCIAL
RELATIONSHIP TO PATIENT – RELACION CON EL PATIENTE	POLICY HOLDER'S EMPLOYER – NOMBRE DEL EMPLEADOR DEL ASEGURO		
PLOICY NUMBER – NUMERO DE POLIZA	GROUP NUMBER – NUMERO DE GRUPO		EFFECTIVE DATE – FECHA DE EFECTO

SECONDARY INS

SECONDARY INSURANCE CP – ASEGURANZA SEGUNDARIA	TELEPHONE – TELEFONO		
ADDRESS – DIRECCION	CITY – CIUDAD	STATE – ESTADO	ZIP – ZONA POSTAL
POLICY HOLDER'S NAME – NOMBRE DE EL ASEGURADO	DOB - FECHA DE NACIMIENTO		SSN – SEGURO SOCIAL
RELATIONSHIP TO PATIENT – RELACION CON EL PATIENTE	POLICY HOLDER'S EMPLOYER – NOMBRE DEL EMPLEADOR DEL ASEGURO		
PLOICY NUMBER – NUMERO DE POLIZA	GROUP NUMBER – NUMERO DE GRUPO		EFFECTIVE DATE – FECHA DE EFECTO

Email Address: ____________________

The above information is complete and correct. I hereby authorize release of information neccessary to file a claim with my nsirance company and I assign benefits otherwise payable to me to the doctor or group indicated on the claim. I understand hat I am financially responsible for all charges for medical services rendered regardless of insurance coverage. A copy of the ignature is as valid as the original.

La informacion obtenida es completa y cortecta. Por este medio usted autoriza el desclosamiento de informacion necesaria al acer reclamos con mi aseguranza. Tambien asigno benefecios que de otra manera serian pagados a mi a que sean asignados a ni doctor o grupo indicado en el relamo. Yo entiendo de que soy responsible por doctors los cargos relacionados a servicios nedicos prestados independientemental tipo de aseguranza.

PATIENT SIGNATURE	DATE	GUARANTOR SIGNATURE	DATE

FRONTIER GASTROENTEROLOGY CENTER

MEDICATION RECORD SHEET

NAME ______________________________ ALLERGIES ____________________
DOB ____________________ ____________________
PHARMACY ____________________ ____________________

MEDICATION	DOSAGE	SIG

FRONTIER GASTROENTEROLOGY CENTER

Welcome to the FRONTIER GASTROENTEROLOGY CENTER. Please fill out the following information to improve the efficiency of our office

Name: ______________________________ Date ______________________________

DOB: ______________________ Social Security Number: ______________________

Have you had any of the following tests recently?

BLOOD TESTS Yes No

If yes, when and where? ____

RADIOGRAPHIC STUDIES (circle all that apply) Yes No

Upper GI Barium enema CT scan Ultrasound

If yes, when and where? ____

ENDOSCOPIC STUDIES (circle all that apply) YES NO

EUD Colonoscopy Flexible Sigmoidoscopy ERCP

If yes, when and where? ____

RECENT HOSPITALIZATION YES NO

If yes, when and where? ____

FRONTIER GASTROENTEROLOGY CENTER

Name: ______________________

Date of Birth: ______________________

Family Doctor: ______________________

Today's Date: ______________________

Chief Complaint: (reason for visit)

____

____

____

____

Hospitalizations/Surgery:
(list illnesses or operations and approximate year)

____

____

____

____

Personal Information:

M____ D____ S____ Sep____ W_____

Occupation: ______________________

Health of Family

(Indicate any illnesses. If no longer living indicate age and cause of death)

Father ______________________

Mother ______________________

Siblings ______________________

Spouse ______________________

Children ______________________

Medicines: (list all medicines, birth control Pills or vitamins you take with or without a prescription, including over-the-counter drugs such as Advil, headache powders, etc.)

____

____

____

____

Allergies: (list all medications you are allergic to)

____

____

____

Family History: (digestive diseases)

RELATION

Gallstones: ______________________

Polyps: ______________________

Pancreatitis: ______________________

Ulcer: ______________________

Liver disease: ______________________

Cancer: ______________________

Social History:

Smoking ______________ Alcohol ______________

Date Reviewed/Updated
(office use only)

____

____

Frontier Gastroenterology Center

3150 N. Tenaya Way, Ste 580, Las Vegas, NV. 89128

(702) 483-5515 (702) 483-5484- Fax

MEDICAL RECORDS RELEASE

DATE: ____________________

TO: ____

____

____

____

I hereby authorize you to release my medical information to:

Frontier Gastroenterology Center

____

____

____

I hereby authorize you to release the following records of any treatment or examination rendered to me during the period from ________________ to ______________________

_____ Endoscopy Reports
_____ X-Ray Report
_____ Pathology Reports
_____ Hospital Consultation
_____ Discharge Summaries
_____ Progress Notes

Other: ____

Signature: __________________________ Date: ______________________________

Printed Name: _______________________ DOB: ______________________________

Witness: ____________________________ Title: ______________________________

FRONTIER GASTROENTEROLOGY CENTER

Acknowledgement of Receipt of Notice of Privacy Practices

FRONTIER GASTROENTEROLOGY CENTER reserves the right to modify the privacy practices outlined in the notice,

Signature
I have received a copy of the Notice of Privacy Practices for FRONTIER GASTROENTEROLOGY CENTER.

____
Name of Patient (Print or Type)

____
Signature of Patient

____
Date

____
Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

____
Relationship of Patient Representative to Patient

************************For Office Use Only****************************

Documentation of Attempt to Obtain Acknowledgement of Receipt of Notice of Privacy Practices Attempt to Obtain Acknowledgement

An attempt was made to obtain an acknowledgement of receipt of the Notice of Privacy Practices on ____________________ The acknowledgement was not obtained because:

[ ] The patient was undergoing emergency treatment

[ ] The patient declined to sign the acknowledgement

[ ] Other ________________________________

Signature

____
Name of Patient (Print or Type)

____
Name of Staff Member

____
Date

Health Information and Privacy Act
Release of Patient Information
Patient Authorization Form

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

I ______________________________ give my authorization for FRONTIER GASTROENTEROLOGY CENTER to use and disclose my protected health information including but not limited to my name or insured's name, name of insurance plan, personal identification number, group or policy number, date of birth, gender, home address, home phone number, legal name, payment information, diagnosis, treatments and procedures, dates and types of hospitalizations, and surgeries The purpose of the requested use or disclosure is obtaining treatment and healthcare operations, reimbursement, referring to other providers, collection agencies and all other medical or hospital services.

By signing this form you consent to our using and disclosing your protected health information as specified in this authorization. You may revoke this authorization in writing, except to the extend that we have acted in reliance on your prior consent To revoke this authorization, you must forward a written revocation referencing this authorization to our chief privacy officer at FRONTIER GASTROENTEROLOGY CENTER.

We may use or disclose your protected health information in the following situations without your authorization. These situation include: as Requested by Law, Public Health issues as requested by law, Communicable Diseases: Health Oversight Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers Compensation: Inmates: Required uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of section 160.500. We are required by law to maintain privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information.

If you choose not to sign this consent, it may be difficult for FRONTIER GASTROENTEROLOGY CENTER to provide treatment. You will be provided with a copy of this signed authorization upon your request

Signature:

Printed Name: ______________________

Date: ______________________

Witness: ______________________

Health Insurance Portability and Accountability act of 1996 (42 U.S. Section 1320d et seq) (45 CFR Subtide A, Subchapter c)

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is now subject to law that prohibits access to protected health information

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices You request must state the specific restriction requested and to whom you want the restriction to apply

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i e , electronically

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us You may file a complaint with us by notifying our privacy contact of your complaint We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Office

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

Print Name: ______________________ Signature __________________________________ Date _________________

Frontier Gastroenterology Center

3150 N. Tenaya, Suite 580
Las Vegas, NV 89128
Phone: 702-483-5515 Fax: 702-483-5484

Financial Policy

We are committed to providing you with the best possible care. **We must emphasize that as medical care providers, our relationship is with you, not your insurance company. Your insurance is a contract between you, your employer and the insurance company, we are not party to that contract.** All charges are your responsibility from the date of service rendered. We realized that insurance companies need processing time; however, all charges will become due and payable if the insurance company does not reimburse **Frontier Gastroenterology Center** within 90 days or within the guidelines mandated by the NV state Board Bill #SB145.

Please familiarize yourself with your insurance policy and its requirements. Many companies require a referral from the primary care physician. **We will attempt to obtain these as a courtesy; however, the policy holder must be pro-active in assuring the requirements are met prior to the visit.**

If you have medical insurance, with whom we are contracted, we will bill your insurance company. All deductibles, co-payments and non-covered items are due at the time of check-in.

Collection Fees Policy: Patient name: ______________________.
I, ______________________ (parent /guardian name), hereby agree to be financially responsible for all charges incurred regardless of insurance coverage. In the event my account is referred to a collection service due to lack of payment on my part, I agree to pay all collection / legal fees that may be added to my account.

______________________ ______________
Signature of patient, parent / guardian Date

Returned Checks: A $25 non-sufficient funds fee will be charges for checks initially returned unpaid by your bank. We repost and forward all returned checks to Clark County District Attorney's office. INITALS: ____

No Show Fees: There is a $25 no-show/late-cancellation fee. All appointments must be cancelled by 3 p.m. of the previous day. Insurance will not cover charges for no-show/late-cancellation. INITALS: ____

PLEASE READ
RETURN TO FRONT DESK

FRONTIER GASTROENTEROLOGY CENTER

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

- Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

- Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

- Health care operations Your health information may be used as necessary to support the day-to-day activities and management of FRONTIER GASTROENTEROLOGY CENTER For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

- Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

- Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

- Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

- Appointment reminders. Your health information will be used by our staff to send you appointment reminders,

- Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you

- Fund raising. Unless you request us not to, we will use your name and address to support our fund-raising efforts. If you do not want to participate in fund-raising efforts, please check off the following box

continue other side

Individual Rights

You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your protected health information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected health information has been disclosed
- the right to receive a printed copy of this notice

FRONTIER GASTROENTEROLOGY CENTER Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices

We also are required to abide by the privacy policies and practices that are outlined in this notice

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modi1~' our privacy policies and practices. These changes in our policies and practices may be required by changes in federal• and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the **Medical Records Clerk** or **Office Supervisor**. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

if you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Privacy Officer
FRONTIER GASTROENTEROLOGY CENTER
3150 N. TENAYA, SUITE 580
LAS VEGAS, NV 89128

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address

You will not be penalized or otherwise retaliated against for filing a complaint

Contact Person

The name and address of the person you can contact for further information concerning our privacy practices is:

Privacy Officer
FRONTIER GASTROENTEROLOGY CENTER
3150 N. TENAYA, SUITE 580
LAS VEGAS, NV 89128
(702) 483-5515

Effective Date This Notice is effective on or after April 14, 2003.

GREAT WEST MEDICAL ASSOCIATES

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician We may also call you by name in the waiting room when your physician is ready to see you We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment

We may use or disclose your protected health information in the following situations without your authorization These situations include: as Required By Law, Public Health issues as required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164 500

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information

FRONTIER GASTROENTEROLOGY CENTER

PATIENT'S BILL OF RIGHTS

The Patient Has The Right To:

- Considerate and respectful care.
- Obtain from physicians and other direct caregivers relevant, current and understandable information about his or her diagnosis, treatment, and prognosis. Except in emergencies when the patient lacks the ability to make decisions and the treatment is urgent
- Discuss and request information related to the specific procedures and/or treatments available, the risks involved, the possible length of recovery, and the medically reasonable alternative to existing treatments along with their accompanying risks and benefits
- Know the identity of physicians, nurses, and others involved in his or her care, as well as when those involved are students, residents, or other trainees. The patient also has the right to know the immediate and long-term financial significance of treatment choices insofar as they are known
- Make decisions about the plan of care before and during the course of treatment and to refuse a recommended treatment or plan of care it is permitted by law and PROVIDER policy. And be informed of the medical consequences of this action. In case of such a refusal, the patient is still entitled to appropriate care and services that the PROVIDER provides or to be transferred to another PROVIDER. The PROVIDER should notify patients of any policy at the other PROVIDER that might effect patient choice
- Have an advance directive (such as a living will, health care proxy, or durable power of attorney for health care) concerning treatment or designating a surrogate decision-maker and to expect that the PROVIDER will honor that directive as permitted by law and PROVIDER policy.
- Know about any PROVIDER policy that may keep it from carrying out a legally valid advance directive. Health care institutions must advise the patient of his or her rights under state law and PROVIDER policy to make informed medical choices, must ask if the patient has an advance directive, and must include that information in patient records.
- Privacy. Case discussion, consultation, examination and treatment should be conducted to protect each patient's privacy.
- Expect that all communications and records pertaining to his/her care will be treated confidentially by the PROVIDER, except in cases such as suspected abuse and public health hazards when reporting is permitted or required by law. The PROVIDER will emphasize confidentiality of this information when it releases it to any other parties entitled to review information in these records.
- Review his or her medical records and to have the information explained or interpreted as necessary, except when restricted by law.
- Expect that, within its capacity and policies, a PROVIDER will make reasonable response to the request of a patient for appropriate and medically indicated care and services. The PROVIDER must provide evaluation, service, and/or referral as indicated by the urgency of the case. When medically appropriate and legally permissible, or when a patient has so requested, a patient may be transferred to another facility. The institution to which the patient is to be transferred must first have accepted the patient for transfer. The patient also must have the benefit of complete information and explanation concerning the need for risks, benefits, and alternative to such a transfer.
- Ask and be told of the existence of any business relationship among the PROVIDER, educational institutions, other health care providers, and/or payers that may influence the patients treatment and care
- Consent to or decline to participate in proposed research studies or human experimentation or to have those studies fully explained before they consent. A patient who declines to participate in research or experimentation is still entitles to the most effective care that the PROVIDER can otherwise provide
- Expect reasonable continuity of care and to be informed by physicians and other caregivers of available and realistic patient care options when PROVIDER care is no longer appropriate
- Be informed of PROVIDER policies and practices that relate to patient care treatment, and responsibilities. The patient has the right to be informed of available resources for resolving disputes, grievances, and conflicts, such as ethics committees, patient representatives, or other mechanisms available in the institution
- Be informed of the PROVIDERS charges for services and available payment methods.

The collaborative nature of health care requires that patient and/or their families and surrogates participate in their care. The effectiveness of care and patient satisfaction with the course of treatment depends, in part, on the patient's fulfilling certain responsibilities:

Patients Are Responsible For:

- Providing information about past illness, hospitalizations, medications and other health-related matters
- Requesting additional information or clarification about their health status or treatment when they do not fully understand the current information or instructions.
- Making sure that the health care institution as a copy of their written advance directive if they have one.
- Informing their physicians and other caregivers if they anticipate problems following prescribed treatment.
- Being aware that the PROVIDER has to be reasonably efficient and equitable in providing care to other patients and the community. The PROVIDER's rules and regulations are designed to help the PROVIDER meet this obligation
- Being considerate of and making reasonable accommodations to the needs of the PROVIDER, other patients, medical staff, and PROVIDER employees
- Providing necessary information for insurance claims and for working with the PROVIDER as needed to make payment arrangements
- Recognizing the impact of their lifestyles on their personal health. A patient's health depends on much more than health care services.

FRONTIER GASTROENTEROLOGY CENTER

Review Of Symptoms

Name ______________________________ Date __________________

PLEASE CIRCLE ANY SYMPTOMS YOU HAVE BEEN EXPERIENCING

Constitutional	Fever	Weight Gain	Weight Loss	Fatigue	Headache
Eyes	Eye Strain	Blurry Vision	Redness	Tearing	
Ears, Nose, Throat	Hearing Changes	Tinnitus	Nose Bleeds	Runny Nose	Hoarseness
Skin	Itching	Rash	Hives	Skin Cancer	Dry Skin
Respiratory	Shortness of Breath	Cough	Wheezing		
Musculoskeletal	Painful Joints	Swelling of Joints	Muscle Cramps	Back Pain	
Cardiac	Chest Pain	Palpitations	Leg Swelling	Pacemaker	
Genitourinary	Frequent Urination	Blood in Urine	Painful Urination	Decreased Flow	
Neurological	Epilepsy	Tingling in Hands or Feet	Memory Loss	Difficulty Speaking	
Psychiatric	Depression	AnxietyStress	Mood Changes		
Endocrine	Breast Discharge	Increased Thirst	Change in Menstrual Cycle		
	Cold Intolerance	Heat Intolerance			
Hematological	Nose Bleeds	Easy Bruising	Swollen Glands	Anemia	

Allergies ____

____

____

Patient Signature ______________________________ Date ______________

The above review of systems was reviewed and discussed with the patient, and noted in the clinical record.

M.D. or PA-C Signature: ______________________________ Date ______________