



TODAY'S DATE: _____

| | | | |
|---|--------------|------------------------------|---------------------|
| NAME: | | SEX M F | DATE OF BIRTH: |
| SSN: | | CURRENT AGE: | |
| STREET ADDRESS: | | CITY, STATE & ZIP: | |
| PHONE # - HOME: () | WORK: () | CELL PHONE #: - () | |
| CAN PERSONAL MESSAGES REGARDING TEST RESULTS, APPOINTMENT TIMES, ETC. BE LEFT AT: | | | |
| HOME | Y or N | WORK | Y or N |
| REFERRED BY: | | PHONE #: () | |
| MARITAL STATUS: (circle one) | | | |
| SINGLE | | MARRIED | DIVORCED WIDOWED |
| EMPLOYER: | | PHONE #: () | |
| IF UNDER 18, PARENT/GUARDIAN: | | NATURE OF ILLNESS/COMPLAINT: | |
| SPOUSE'S NAME: | | SPOUSE'S DATE OF BIRTH: | |
| SPOUSE'S SOCIAL SECURITY NO. (For Billing Purposes) | | | |
| SPOUSE'S EMPLOYER: | | PHONE #: () | |
| EMERGENCY CONTACT: | | PHONE #: () | |

If your insurance plan requires prior authorization, it must be obtained prior to your appointment.
Do you have the authorization today? Yes No If no, please see front desk personnel.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to Dr.'s Alan Cutler, Janice Fields, Phillip Goldmeier, Randall Jacobs, Jay Levinson, Luis Maas, Michael Piper, Bradley Warren and Edward Yousif, doing business as Digestive Health Associates, PLC, for services rendered by him/her in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr.'s Alan Cutler, Janice Fields, Phillip Goldmeier, Randall Jacobs, Jay Levinson, Luis Maas, Michael Piper, Bradley Warren and Edward Yousif, doing business as Digestive Health Associates, PLC, to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

MEDICARE/MEDICAID

I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

A photocopy of these assignments shall be valid as the original.

PATIENT NAME (please print) _____ DATE _____

PARENT/GUARDIAN (please print) _____

SIGNATURE: _____

Alan F. Cutler, M.D., F.A.C.G., F.A.C.P.
Janice M. Fields, M.D., F.A.C.G., F.A.C.P.
Phillip A. Goldmeier, M.D., F.A.C.G.
Randall S. Jacobs, M.D., F.A.C.G., F.A.C.P.
Jay R. Levinson, M.D., F.A.C.G.

Luis C. Maas, M.D., F.A.C.G., F.A.C.P., A.G.A.F.
Michael H. Piper, M.D., F.A.C.G., F.A.C.P.
Bradley J. Warren, D.O., F.A.C.G., F.A.C.O.I.
Edward A. Yousif, M.D., F.A.C.G.



Board Certified in Gastroenterology

Acknowledgement of Receipt of Notice of Privacy Information Practices

My signature on this form indicates that I have received a Notice of Privacy Information Practices.

In the event that I have questions, I have been given the name of the Privacy Officer, whose information is listed below, who will be able to answer my questions.

Privacy Officer

Karen Tong, Director of Operations

30055 Northwestern, Ste. 250
Farmington Hills, MI 48334
248-985-5000

11900 E. 12 Mile Road, Ste 307
Warren, MI 48093
586-573-8380

I request the following restrictions to the use or disclosure of my PHI. I understand you may or may not agree to my request. I also understand if you agree to the restriction, if the restricted information is needed to provide me with emergency treatment, you may suspend the agreement and provide a health care provider with any needed information.

- I do not wish messages left on my voice mail at: _____
- I do not wish to be contacted by fax machine.
- I do not wish to be contacted by email.

- I wish **only** the following person(s) to receive my protected health information.

Name: _____ Relation: _____ Birth date _____

Name: _____ Relation: _____ Birth date _____

Other: _____

Print Name

Signature of Patient or Legal Representative

Date

Office Use Only:

- Accepted Restrictions
- Denied Restrictions

Signature

Title

Date

30055 Northwestern #250 • Farmington Hills, MI 48334 • 248.985.5000 • 248.985.5500 fax
11900 E. 12 Mile Road #307 • Warren, MI 48093 • 586.573.8380 • 586.573.8979 fax
www.digesthealth.com

• PLEASE COMPLETE BOTH SIDES OF THIS FORM •



**DIGESTIVE
HEALTH
ASSOCIATES, P.C.**

DATE: _____

PATIENT NAME: _____

MALE / FEMALE

AGE: _____ OCCUPATION: _____ FAMILY DOCTOR: _____

FAMILY DR'S ADDRESS: _____ PHONE: _____

OTHER DRS. YOU SEE: _____

CURRENT AND PAST MEDICAL PROBLEMS (Ex.: High blood pressure, diabetes, etc.)

ILLNESS: _____

PAST SURGICAL HISTORY

| OPERATION | YEAR | REASON |
|-----------|-------|--------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

OTHER HOSPITALIZATIONS

| NAME OF HOSPITAL | YEAR | REASON |
|------------------|-------|--------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

FOREIGN TRAVEL

PLACE: _____ YEAR: _____
_____ YEAR: _____

ALLERGIES TO MEDICATION

NAME: _____ REACTION: _____

PLEASE LIST PRESENT MEDICATIONS

NAME: _____ DOSAGE: _____

DO YOU USE ASPIRIN OR ARTHRITIS MEDICATIONS? _____

SOCIAL HISTORY

HABITS: Smoking (cigarettes, pipe, cigars) HOW MUCH? _____
Alcohol (wine, beer, liquor) HOW MUCH? _____

DIET

(Please indicate how much is used)

COFFEE: _____ CHOCOLATE: _____ FIBER: _____

TEA: _____ MINTS/GUM: _____ POP: _____

MILK OR DAIRY PRODUCTS: _____

FOOD INTOLERANCE: _____

FAMILY HISTORY

| LIVING OR DECEASED | AGE (now or at death) | ILLNESS OR CAUSE OF DEATH |
|---------------------|--------------------------|---------------------------|
| FATHER: _____ | _____ | _____ |
| MOTHER: _____ | _____ | _____ |
| (list individually) | | |
| SISTERS: _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| BROTHERS: _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| CHILDREN: _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

ANY FAMILY MEMBERS KNOWN TO HAVE COLON CANCER OR POLYPS? YES NO

IF YES, RELATIONSHIP TO PATIENT: _____

REVIEW OF SYSTEMS

HAVE YOU RECENTLY HAD ANY:

| General: | Y | N | Eyes/Ears/Mouth: | Y | N | Cardiac: | Y | N | Muscles/Skeleton: | Y | N |
|-----------------------|--------------------------|--------------------------|-----------------------|--------------------------|--------------------------|-----------------------|--------------------------|--------------------------|-----------------------|--------------------------|--------------------------|
| Trouble sleeping | <input type="checkbox"/> | <input type="checkbox"/> | Vision trouble | <input type="checkbox"/> | <input type="checkbox"/> | Heart problems | <input type="checkbox"/> | <input type="checkbox"/> | Joint pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Change in weight | <input type="checkbox"/> | <input type="checkbox"/> | Double vision | <input type="checkbox"/> | <input type="checkbox"/> | Chest pain | <input type="checkbox"/> | <input type="checkbox"/> | Morning stiffness | <input type="checkbox"/> | <input type="checkbox"/> |
| Loss of energy | <input type="checkbox"/> | <input type="checkbox"/> | Eye pain | <input type="checkbox"/> | <input type="checkbox"/> | Heart murmurs | <input type="checkbox"/> | <input type="checkbox"/> | Back problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Fevers/Chills | <input type="checkbox"/> | <input type="checkbox"/> | Hearing trouble | <input type="checkbox"/> | <input type="checkbox"/> | Heart attacks | <input type="checkbox"/> | <input type="checkbox"/> | Neurologic: | | |
| Night sweats | <input type="checkbox"/> | <input type="checkbox"/> | Ringing in ears | <input type="checkbox"/> | <input type="checkbox"/> | Fainting | <input type="checkbox"/> | <input type="checkbox"/> | Blankouts | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Dizziness | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty laying | <input type="checkbox"/> | <input type="checkbox"/> | Seizures | <input type="checkbox"/> | <input type="checkbox"/> |
| Skin: | | | Dental problems | <input type="checkbox"/> | <input type="checkbox"/> | Gastrointestinal: | | | Frequent headaches | <input type="checkbox"/> | <input type="checkbox"/> |
| Rashes | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty swallowing | <input type="checkbox"/> | <input type="checkbox"/> | Abdominal pain | <input type="checkbox"/> | <input type="checkbox"/> | Muscle weakness | <input type="checkbox"/> | <input type="checkbox"/> |
| Changes in skin color | <input type="checkbox"/> | <input type="checkbox"/> | Mouth sores | <input type="checkbox"/> | <input type="checkbox"/> | Heartburn | <input type="checkbox"/> | <input type="checkbox"/> | Trouble talking | <input type="checkbox"/> | <input type="checkbox"/> |
| Unhealed sores | <input type="checkbox"/> | <input type="checkbox"/> | Hoarseness | <input type="checkbox"/> | <input type="checkbox"/> | Nausea/Vomiting | <input type="checkbox"/> | <input type="checkbox"/> | Balance problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood: | | | Lungs: | | | Diarrhea | <input type="checkbox"/> | <input type="checkbox"/> | Memory changes | <input type="checkbox"/> | <input type="checkbox"/> |
| Unusual bleeding | <input type="checkbox"/> | <input type="checkbox"/> | Nose bleeds | <input type="checkbox"/> | <input type="checkbox"/> | Constipation | <input type="checkbox"/> | <input type="checkbox"/> | Emotion: | | |
| Easy bruising | <input type="checkbox"/> | <input type="checkbox"/> | Cough | <input type="checkbox"/> | <input type="checkbox"/> | Blood in stool | <input type="checkbox"/> | <input type="checkbox"/> | Mood swings | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath | <input type="checkbox"/> | <input type="checkbox"/> | Urinary: | | | Crying spells | <input type="checkbox"/> | <input type="checkbox"/> |
| Enlarged glands | <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Burning in urine | <input type="checkbox"/> | <input type="checkbox"/> | Depression | <input type="checkbox"/> | <input type="checkbox"/> |
| Endocrine: | | | Cold | <input type="checkbox"/> | <input type="checkbox"/> | Blood in urine | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric treatment | <input type="checkbox"/> | <input type="checkbox"/> |
| Heat/Cold intolerance | <input type="checkbox"/> | <input type="checkbox"/> | | | | Increased urine | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Hair growth/loss | <input type="checkbox"/> | <input type="checkbox"/> | | | | Flank pain | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Increased thirst | <input type="checkbox"/> | <input type="checkbox"/> | | | | Trouble in stop/start | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Increased hunger | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | |

Review w/Patient: _____ Updated: _____
Initials Date Initials Date