Digestive Disease Associates, PC

Montgomery, Alabama

Welcome to the office of Digestive Disease Associates, P.C. Our patients are scheduled on Mondays, Wednesdays, and Thursdays. Every patient seen by Digestive Disease Associates, P.C. should have a primary care physician (internists or general practitioner). We accept patients on a physician-referral basis only.

NEW PATIENT INFORMATION

Please Print Date_____

Name_____Date of Birth_____Age_____

Address_____

City_____State_____Zip Code_____Phone (____)_____

Occupation/Employer_____Phone (____)_____

Social Security No._____Drivers License No._____Cell (____)_____

Spouse_____Spouse's Employer_____

Emergency Contact_____Address/Phone_____

Referring Physician_____

INSURANCE/BILLING INFORMATION

Insurance Company_____Effective Date_____

Subscriber_____ID#_____Group#_____

Address_____

Insurance Company_____Effective Date_____

Subscriber_____ID#_____Group#_____

Address_____

I hereby authorize the release of any medical information that may be necessary for either medical care or in processing applications for financial benefit. I hereby authorize direct payment of benefits to Digestive Disease Associates, P.C. for services rendered by them in person or under their supervision. I understand that I am financially responsible for all charges regardless of insurance coverage.

AGREEMENT TO PAY: The undersigned accepts the fee charged as lawful debt and promises to pay said fee including the cost of collection, attorney fees and court costs if such be necessary, waiving now and forever the right to claim exemption under the Constitution and Laws of the State of Alabama, or any other state.

Signature_____ Date_____

Digestive Disease Associates, PC

ROBERT R. BRINSON, M.D.

MEDICAL HISTORY

DATE_____

NAME_____AGE_____

PERSONAL PHYSICIAN :_____

REFERRED:_____

REASON FOR DOCTOR VISIT:_____

SECTION I: HISTORY OF PRESENT ILLNESS (IF APPLICABLE)

(1) State location of problem_____

(2) State quality (i.e. --sharp, stabbing pain, achy, burning, etc)

_____

(3) State severity (i.e. --mild, moderate, severe)

_____

(4) State duration (i.e. --continuous, intermittent)

_____

(5) State timing (i.e. --after eating greasy food, certain time of day, aggravating circumstances)

_____

(6) State other signs/symptoms (such as nausea, vomiting, etc)

_____

BRIEF = 1-3 EXTENDED = 4 OR MORE

SECTION II: REVIEW OF SYSTEMS CHECK BLANK & CIRCLE SYMPTOMS

___ CONSTITUTIONAL PROBLEMS: Night sweats, Fever, Chills, Dry mouth

___ EYES: Cataracts, Blurred vision, Glaucoma, Blindness, Glasses, Contacts, Eye irritation

___ EARS, NOSE, MOUTH, THROAT: Decreased hearing, Ringing, Ear infections; Bleeds, Sinus trouble; Mouth ulcers, Bleeding gums, Cancer

___ RESPIRATORY: Asthma, Emphysema, Wheezing, Bronchitis, Frequent cough, Pneumonia, Shortness of breath, Other:_____

___ GASTROINTESTINAL: Ulcers (stomach, duodenal), Hiatial hernia, Vomiting up blood, Gallbladder disease, Pancreatitis, Liver disease, Jaundice, Difficulty swallowing, Blood in stool, Colitis Inflammatory bowel disease, Hemorrhoids, Change in bowel habits, Constipation

___ GENITOURINARY: Kidney stones, Kidney or bladder infection, Kidney failure, blood in urine

___ FEMALE PROBLEMS: Ovarian problems, Uterine, Abnormal bleeding, Infections, Menopause

___ MALE PROBLEMS: Prostate, Frequent voiding at night, Straining to void, Impotence

___ MUSCULOSKELETAL: Hernias (groin, abdominal), Gout, Arthritis (location_____), Broken bones (location_____), Other (_____)

___ NEUROLOGICAL: Seizures, Dizzy spells, Severe headaches, Paralysis, Head injury

___ PSYCHIATRIC: Anxiety, Depression, Mental illness, Eating disorders, Other:_____

___ ENDOCRINE: Thyroid, Diabetes, Adrenal, Recent weight gain/loss, Steroid use history, High cholesterol, Other:_____

___ HEMATOLOGIC/LYMPHATIC: Hepatitis, AIDS, HIV, Malaria, Bleeding disorder, Other:_____

___ ALLERGIES: Runny Nose, Chronic cough, eczema, Other:_____

EXTENDED = 2 TO 9 COMPLETE = 10 OR MORE

SECTION III: PAST FAMILY AND/OR SOCIAL HISTORY

PAST HISTORY:

Current Medications: (prescription and over the counter)

1. _____	5. _____	9. _____
2. _____	6. _____	10. _____
3. _____	7. _____	11. _____
4. _____	8. _____	12. _____

Drug Allergies:_____

Family History	If Living		If Deceased	
	Age	Health	Age@Death	Cause
Father				
Mother				
Brothers/Sisters				
Husband/Wife				
Sons/Daughters				

Prior Hospitalizations or Surgery: (Do not include normal pregnancies)

	Reason	Year

Other Symptoms:

__Diabetes	__Cancer	__Heart Attack	__Bloody Stools	__Transfusion
__COPD	__Diarrhea	__Ulcer	__Hemorrhoids	__High Cholesterol
__Asthma	__Diverticulosis	__Venereal Disease	__Moodiness	__Headaches
__Heart Murmur	__Black Stools	__Gout	__Allergies	__Loss of Appetite
__Colon Polyps	__Depression	__Anxiety	__High Blood Pres.	__Difficult Swallow
__Arthritis	__Indigestion	__Gall Stones	__Hepatitis	__Rheumatic Fever
__Stroke	__Alcoholism	__Mental Illness	__Jaundice	__Heartburn
__Anemia	__Chronic Fatigue	__Constipation	__AIDS/HIV	__Nausea/Vomiting

Personal Habits:

Do you smoke? How long? How many packs per day?

Do you chew tobacco? How long?

Do you drink alcohol?

Do you exercise regularly?

Do you drink coffee? Other caffeines?

Do you eat breakfast? Lunch? Dinner?

How long does it take you to eat your meals?

Do you eat late at night?

PERTINENT = 1 AREA COMPLETE = 2 OR 3 AREAS

DOCTOR/NURSE USE ONLY

	PROB FOCUSED	EXPANDED PROBLEM FOCUSED	DETAILED	COMPREHENSIVE
COMPLAINT	CHIEF	CHIEF	CHIEF	CHIEF
HISTORY-ILL	BRIEF	BRIEF	EXTENDED	EXTENDED
SYSTEM REVIEW		PERTINENT	EXTENDED	COMPLETE
HISTORY - P.F.S			PERT	COMPLETE

EVALUATION AND MANAGEMENT SERVICE CODES

NEW PATIENT CODES						ESTABLISHED				
	99201	99202	99203	99204	99205					
	99241	99242	99243	99244	99245	99211	99212	99213	99214	99215
HISTORY	PF	EPF	D	C	C	*	PF	EPF	D	C
EXAMINATION	PF	EPF	D	C	C	*	PF	EPF	D	C
MEDICAL DECISION MAKING	SF	SF	LC	MC	HC	*	SC	LC	MC	HC
TIME	10	20	30	45	60	5	10	15	25	40
TIME PRESENTING PROBLEM	MINOR	LOW	MOD	MOD-HI		HIGH	MIN	MINOR	LOW	MODHIGH

PF:	PROBLEM FOCUSED	LC:	LOW COMPLEXITY
EPF:	EXPANDED PROBLEM FOCUSED	MC:	MODERATE COMPLEXITY
D:	DETAILED	HC:	HIGH COMPLEXITY
C:	COMPREHENSIVE	*:	MINIMAL PROBLEMS
SF:	STRAIGHT FORWARD		

MEDICAL RECORDS FAX TRANSMISSION AUTHORIZATION

I, _____, understand that you will be transmitting my medical records electronically and this is your authorization to do so. If they are received by another party in error, I absolve **Robert R. Brinson, M.D.** of any and all liability relating to such submission of said records.

Signature_____

Date_____

Digestive Disease Associates, PC

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Robert R. Brinson, M.D.
Diplomate, American Board of Internal Medicine
Diplomate, Subspecialty Board of Gastroenterology
Fellow, American College of Nutrition

Gastroenterology
Clinical Nutrition
Hyperalimentation

Medical Release For:_____

Effective October 1, 2000 (due to federal guidelines under HIPPA) we are now required to have and maintain in a patient's medical chart medical release information on family members, friends, caregiver, etc. You must provide the names of those individuals who you wish to be given any or all of your medical or financial information. ANYONE calling for medical or financial information on you who is not listed on this sheet will be told that no information can be released to them.

Please list the names, dates of birth and phone numbers of the authorized individuals below. The individuals listed below have to agree to provide their D.O.B. or phone numbers for identification purposes.

1). If you DO NOT want your medical or financial information discussed with anyone other than yourself, please sign here: _____ Date: _____

2). I (sign here) _____ (patient's name) give authorization to the following individual(s) listed below to discuss my medical or financial information with your staff or the Doctor on my behalf.

Name	D.O.B.	Phone Number
1)_____	_____	_____
2)_____	_____	_____
3)_____	_____	_____

If there is any medical or financial information you do not wish to be given out please list below:

_____

_____

May we leave medical information on your "home" answering machine? Yes_____ No_____

Signature of Patient _____ Date_____

The above information is private and confidential and will be placed in your medical chart. This information must be updated and a new form signed one year from the date above.

Although the law requires a signed and dated Privacy Notice, this office does not demand that you sign the agreement as a condition of receiving care. It is the law that you rights are communicated in this manner.

It is our practice to retain information about non-healthcare related requests for your health care information for a period of six years.

In complying with the Privacy Standard, we have appointed a Privacy Officer, trained our Privacy Officer and the staff in the law, and implemented policies to protect your PHI. We have instituted privacy and security processes to guard and protect your IIHI. This office is taking and continues to monitor and improve steps for the protection of your information and to remain in compliance with the law.

Please sign below and date the form indicating that you have received this Privacy Notice.

Signature of Patient _____ Date_____