DONALD A. GIRARD, MD, FACG
GASTROENTEROLOGY
EXPERIENCE. PERSONAL CARE. RESULTS.

Dear Patient:

I would like to take this opportunity to welcome you to my practice. Your primary care physician _____ has requested that you be scheduled for a colonoscopy. Enclosed please find a brochure explaining the procedure.

Enclosed you will find a new patient registration, medical history form and consent forms for my office and the facility. Please complete ALL forms in full and return to my office as soon as possible so that we may schedule your procedure for you. No procedure will be scheduled until the material is received and completed in full.

Sincerely,

Donald A. Girard M.D., F.A.C.G

5211 W. WOODMILL DRIVE, SUITE 36 • WILMINGTON, DELAWARE 19808 • PHONE: (302) 633-5755 FAX: (302) 633-5751

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IMPORTANT INFORMATION

Please bring your most current insurance card/s to all your office appointments or any appointment at an out-patient facility or hospital.

We ask that you make sure all referrals are obtained one week prior to your scheduled appointment from your primary care physician. This includes referrals for office appointments or out-patient procedures.

Without any of the information listed above your appointment may be rescheduled.

Thank you

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Medical History Form

Name:_____ Date:_____

Date of Birth:_____ Sex: __M __F Occupation:_____

Briefly describe why you are being referred or your current symptoms: _____

_____

_____

_____

Have you ever had a colonoscopy and/or flexible sigmoidoscopy? If so, when and by whom? _____

_____

List current medications:

Name	Dosage	How often	Name	Dosage	How often
1.			1.		
2.			2.		
3.			3.		
4.			4.		
5.			5.		

Have you had any of the following? (Please Check)

__ High Blood pressure __Diabetes __Stroke __Heart disease

__Rheumatic heart disease __Kidney disease/stones __Thyroid disease __Cancer

__Tuberculosis __Blood transfusions __Bleeding tendency __Esophagitis

__Heart murmur __Stomach ulcers __Colon Polyps

__Gall bladder disease __Ulcerative colitis __Crohn's disease

__Diverticulitis __Asthma/emphysema __Hepatitis/jaundice

Drug Allergies: (Please list and Describe)

Drug	**Reaction**	**Drug**	**Reaction**
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____

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3. _____ _____ 6. _____ _____

Please list all prior surgeries and dates:

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

List other hospitalizations:

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Social Habits:

Do you smoke? __ Now __ Previously _____packs/day for ____ years

Do you drink alcohol? __ Now __Previously How much per day/week? _____

Have you ever used recreational or intravenous drugs? __ Yes __No

Family History: Do you have a family history (parents and/or siblings) of: (Please check) If so, whom? _____

__ Colon cancer _____ __Colon Polyps _____ __Ulcerative colitis _____

__Peptic ulcers _____ __Gall bladder disease _____ __Pancreatic cancer_____

__Kidney disease_____ __Thyroid disease_____ __High Blood pressure_____

__Breast cancer_____ __Uterine cancer_____ __Crohn's disease_____

__Heart disease _____

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	Age	Alive (Y/N)	Health Problems / Cause of Death
Mother			
Father			
Siblings(Brother or Sister)			
Children			List Chronic Health Problems

DO YOU PRESENTLY HAVE (Please check)

Constitutional: __ Recent weight change __ Fatigue ___Fever Weight_____

Eyes: __Double vision __Glaucoma __Cataracts __Vision loss

Ears, nose, mouth, throat: __Ringing in ears __Dizziness __Hearing loss __Nosebleeds __Sinus trouble

__Bleeding gums __Hoarseness

Cardiovascular: __Heart murmur __Chest pains __Palpitations __Shortness of breath

__Leg pains with walking __Phlebitis

Respiratory: __Cough __Coughing up blood __ Pain with breathing

Gastrointestinal: __Trouble swallowing __nausea __Vomiting __ Blood in stools __ Diarrhea

__Constipation __Black stools __Abdominal pain

Genitourinary: __Frequent urination __Painful urination __Blood in urine __incontinence

Musculoskeletal: __Muscle or joint pain __Arthritis __Gout

Skin: __Rashes __Sores __Itching

Psychiatric: __Depression __Anxiety __History of psychiatric problems

Endocrine: __Thyroid trouble __Heat or cold intolerance __Excess thirst or hunger

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Hematologic: __Anemia __Swollen glands

Men: __penile discharge __Testicular pain or masses

Women: __Irregular menstrual periods Date of last menstrual period_____

Date of last pelvic and breast exam_____ Date of last mammogram_____

Are you currently being tested for any conditions not mentioned above? __Yes __No

If Yes, please list

_____

_____

_____

_____

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MEDICAL INFORMATION RELEASE AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Date: _____ Signature:_____

I hereby authorize Dr. Donald A. Girard M.D. to apply for benefits on my behalf for covered services rendered by him, or by his order. I request that payment from my insurance company be made directly to Dr. Donald A. Girard M.D. (or to the party that accepts assignment).

I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Date:_____ Signature:_____

Patient, parent, or legal guardian

STATEMENT OF FINANCIAL RESPONSIBLILTY

I acknowledge that Dr. Donald A. Girard M.D.; F.A.C.G. my bill my insurance as a courtesy to me, but the financial responsibility for any and all charges incurred during my treatment is mine. In consideration of the services rendered, I promise to pay Dr. Donald A. Girard M.D.; F.A.C.G. the full amount of charges for said services upon demand or in accordance with payment arrangements agreed by them. I consent to permit Dr. Donald A. Girard M.D.; F.A.C.G. as with other institutions that extend credit, access my credit report through a nation credit reporting agency, and to use this information in determining the method, timing, and amount of any payments. If I fail to keep this promise, I understand that I will also be responsible for paying the costs of collection.

I understand that if I do not pay the patient due balance in a timely manner and must be sent to a collection agency, that thirty five percent of my outstanding balance will be added to the amount due to cover costs of collections. I agree to pay this cost in addition to the outstanding balance for services rendered.

_____ _____

Signature of Patient, Parent, Guardian Date

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ASSIGNMENT OF MEDICARE BENEFITS

_____

Medicare Number

I request that payment of Medicare benefits for services rendered to me by Dr. Donald A. Girard M.D.; F.A.C.G.

_____

Signature

Dr. Donald A. Girard M.D.; F.A.C.G., Medicare signature on File

CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATION

Protected health information may be used and disclose by Dr. Donald A. Girard M.D.; F.A.C.G. to carry out treatment, payment and health care operation. Please see Dr. Donald A. Girard M.D.; F.A.C.G.. Notice about uses and disclosures of information described in this Consent. You have the right to review the Notice before signing this Consent. I consent to Dr. Donald A. Girard M.D.; F.A.C.G. to release protected health information of:

Patient:_____ Date of Birth:_____

I understand that signing this Consent authorizes Dr. Donald A. Girard M.D.; F.A.C.G. to release protected health information including but not limited to, any information acquired in the course of my examination and/or treatment and any information needed to determine benefits or benefits payable for related services to:(1) my insurance company; (2) Centers or Medicare and Medicaid services (“CMS”) or (3) any healthcare provider in the furtherance of my treatment. I understand that Dr. Donald A. Girard M.D.; F.A.C.G. may refuse treatment of may refuse further treatment if I do not sign this consent or If I revoke this Consent. I understand that I may revoke this consent at any time, in writing, but my revocation will not be effective as to any consent Dr. Donald A. Girard M.D.; F.A.C.G. has relied upon. I understand that I have the right to request restrictions on Dr. Donald A. Girard M.D.; F.A.C.G. uses and disclosures of protected health information, even though Dr. Donald A. Girard M.D.; F.A.C.G. does not necessarily have to agree to my requested restrictions.

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PATIENT INFORMATION

To provide our office with the correct and complete information regarding your address and health insurance, please complete the following: **PLEASE PRINT INFORMATION REQUIRED.**

Last Name: _____First Name: _____M.I. _____Sex: ___F____M

Street Address_____Apt #_____Phone:(___)_____

City: _____State:_____ZipCode_____

DOB:_____Social Security #:_____-_____-_____Marital Status: ___S___M___D___W

Ethnicity: _____Religious Preference:_____

Primary Care Physician: _____

Primary Care Physician Address_____Phone: (_____)_____

Employer:_____Work Phone:(_____)_____

Who to Notify in case of an emergency: Do you have a Living Will? ____Y_____N

Name:	Phone #	Relationship
1._____	_____	_____

Pharmacy:._____Phone:(_____)_____

INSURANCE POLICY INFORMATION

PRIMARY Insurance Carrier:_____Phone#:(____)_____

Address:_____City_____State_____Zip_____

Ins. ID #:_____Group#:_____

Policy Holder:_____DOB:_____SSI #:_____-____-_____

Employer:_____Employer Ins. Plan? _____Y_____N

Relationship:____Spouse ___Parent ___Child ___Other Copay: ___$10 ___$15 ___$20 ___Other

SECONDARY Insurance Carrier: _____Phone: (____)_____

Address:_____City:_____State:_____Zip:_____

Ins. ID #:_____Group#:_____

Policy Holder:_____DOB:_____SSI #:_____-____-_____

Employer:_____Employer Ins. Plan? _____y_____N

Relationship:____Spouse _____Parent ____Child ____Other

Copay: ___$10 ___$15 ___$20 ___Other

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CONSENT FOR TREATMENT, RELEASE OF PHI AND RECEIPT OF PRIVACY PRACTICE NOTICE

I am in receipt of a copy of the Notice of Privacy Practices**.** I give consent to Donald A**.** Girard, M.D., F.A.C.G. and his office for treatment, use and disclosure of my PHI (Protected Health Information) to carry out medical treatment, payment, and all other healthcare operations.

With this consent, Donald A. Girard, M.D., F.A.C.G. and his office may contact me by telephone and /or place of employment or any other location I may be reached at, if I am unavailable they may leave a message with a person or voice mail. This includes mail at the address I have provided or by fax if applicable to expedite appointment scheduling, appointment reminders, billing and other healthcare operations.

If I do not sign this consent or revoke it at a later date, Donald A. Girard, M.D., F.A.C.G. may decline treatment or any other medical information to me.

_____ _____

Patient's/ Legal Guardian Signature Date

_____

PRINT Patient's/ Legal Guardian l Signature