THESE FORMS MUST BE COMPLETED AND RETURNED AT LEAST 24 HOURS PRIOR TO YOUR SCHEDULED APPOINTMENT FOR ONLINE DRUG INTERACTION SCREENING

FLORIDA DIGESTIVE HEALTH SPECIALISTS

DBA

SARASOTA DIGESTIVE HEALTH SPECIALISTS

1801 Arlington St. Suite 101 Sarasota, FL 34239 Phone:(941)894-3490 Fax:(941)894-3494

Updated Patient Health History

Name_____ Today's Date_____

Address_____ Home Phone _____

City_____ State_____ Zip Code_____ D.O.B.__-__-____ Cell Phone_____

Social Security #_____-_____-_____ Sex (M/F) _____ Marital Status_____ Work Phone_____

Race/Ethnic Heritage (Ex: Caucasian/Irish-German Etc.) _____/_____ Preferred Language_____

Have you seen another Gastroenterologist since your last visit? Y or N (Circle One)

If Yes: Physicians Name:_____ Date of Visit:_____ Reason:_____

DOCTOR & PHARMACY INFORMATION

Referring MD_____ Primary Care MD_____ Cardiologist_____

Pharmacy Name_____ Pharm. Phone #_____ Pharm. Address_____

INSURANCE INFORMATION

Company Name:_____ Member Name:_____

Member ID#_____ Group # / Name:_____

PRESCRIPTION MEDICATIONS (Write N/A if None)

Medication Name _____ Strength _____ How Often

_____

_____

_____

_____

_____

_____

_____

_____

SUPPLEMENTS

Name Only

_____

_____

_____

_____

_____

_____

_____

_____

Drug Allergies (Write N/A if None)_____

Conditions: (Past and Present) (Circle N/A if None) N/A

Alcoholism Arrhythmia Barrett's Colitis COPD Diverticulitis Heart Attack Hypertension Pacemaker

Anxiety Arthritis Cardiac Stent Colon CA Diabetes Gall Stones Hemorrhoids IBS Pancreatitis

Anemia Asthma Cirrhosis Colon Polyps Depression GERD Hepatitis Kidney Problems Stroke

Cancer (type)_____

Past Surgeries & Dates (Write N/A if None)

_____

_____

_____

Previous Colonoscopy: Y or N Year_____ Where_____ MD_____

Previous Upper Endoscopy: Y of N Year_____ Where_____ MD_____

SOCIAL HISTORY(Write N/A if None)

Alcohol: Y/ N How Much?_____ DAILY / WEEKLY Tobacco: Y/ N How Much? _____DAILY / WEEKLY

Former Tobacco Use? Y or N Caffeine (Coffee, Tea, Soda): Y or N How Much? _____ DAILY / WEEKLY

Family History of GI Problem and/or Cancer

Mother: _____ Father: _____ Sister: _____

Brother: _____ Children: _____ Other: _____

Florida Digestive Health Specialists

SDHS, 1801 Arlington St., Sarasota, FL 34239
Dr. Isaac Kalvaria and Dr. John Southerland
Office(941)894-3490 Fax(941)894-3494

HIPAA ACKNOWLEDGEMENT/
ALTERNATE COMMUNICATION FORM

I acknowledge that I have received a copy of Florida Digestive Health Specialists Notice of Privacy Practices. The effective date of this notice is July 1, 2012.

Signature of patient or responsible person _____ Date _____

Relationship of Representative to Patient_____ Date _____

Signature of witness _____ Date _____

_____

HIPAA ACKNOWLEGEMENT AND RELEASE

This notice describes how your medical information may be used and disclosed and how you can get access to this information. Please review carefully. By signing this waiver I release Florida Digestive Health Specialists Physicians and its staff, from any liability for release of information pertaining to my medical care.

Patient Name _____ Date of Birth ____/____/____
(Print full name)

I wish to be contacted in the following manner (check all that applies):

By home, cell or work phone as indicated below:

Home	Cell	Work	
[ ]	[ ]	[ ]	O.K. to leave message on voicemail
[ ]	[ ]	[ ]	O.K. to leave message with individual
[ ]	[ ]	[ ]	Leave message with call back number only
[ ]	[ ]	[ ]	Do not leave message

By written communication as indicated below:

[ ] O.K. to mail to my home address(s)
[ ] O.K. to fax to this number
[ ] O.K. to email address on registration

_____I

I, _____, DOB ____/____/____ give permission to the following individuals to obtain the
(Name of Patient)
indicated information:

_____ whose relationship to me is _____ Phone ( )____-_____
(Name of Person) (Relationship to Patient)

_____ whose relationship to me is _____ Phone ( )____-_____

_____ Prescription refills on my behalf
_____ Test results on my behalf
_____ Set up appointments/or cancel on my behalf
_____ Speak to the doctor/MA either in person or by telephone on my behalf
_____ Pick up prescriptions, doctor's orders or other needs on my behalf with a photo ID

Effective Date _____ Expires _____ Revoked _____

It is the responsibility of the patient to notify the physician's office, in writing, if there is a change in this information.

F04-8/9/12

Florida Digestive Health Specialists

d/b/a Sarasota Digestive Health Specialists
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Communication Agreement Form

Dear Valued Patient,

Thank you for choosing Florida Digestive Health Specialists, team of physicians, at Location Name to participate in your healthcare.

As a participant in your own healthcare it is your responsibility to assure that there is a clear and open method of communication from our office to you. It is also your responsibility to insure that this office always has a way to contact you to communicate test results and other important matters relating to your medical care.

Along the way, we will recommend/perform diagnostic studies which we feel are important to your well- being. These diagnostic studies are to diagnose your ailment(s), define treatment strategies and to maintain your health. As with all diagnostic studies, we are at times unpleasantly surprised by the results. These results can include cancer or other potentially fatal conditions, which if undiagnosed or diagnosis is delayed, can result in death or a serious disability. Some of these studies will be at the time of an active issue, and other times it will be recommended for the future, (maybe even ten (10)years in the future).

We pride ourselves in attempting to contact every single patient with results of diagnostic studies and reminders for follow-up issues. There will be times that we are unable to contact you or we do not yet have the results in our office. Ultimately, if you do not hear from us within 14 days regarding your test results, it is your responsibility to contact us.

By initialing below and signing this letter you agree to the following:

(Please initial each line)

1. Call our office two weeks after any diagnostic study, if we have not notified you with results. _____
2. Call our office again, for any issue, if we do not return your call. _____
3. Immediately notify our office of a change of address and/or contact telephone numbers. _____
4. Keep a written record of when your diagnostic studies are scheduled and notify our office if you cannot comply. _____
5. Keep a written record of your future follow-up needs, even if it is ten years in the future. _____

All of the above lines 1 thru 5 are very important. However, if you do not immediately notify this office of any change in address or contact telephone numbers, it limits our ability to communicate important matters pertaining to your care.

By signing this letter you are agreeing that the responsibilities and obligations outlined in lines 1 through 5 are important to your future health and that you will comply with these obligations.

Thank you so much we look forward to a mutually gratifying relationship.

The Physicians of Florida Digestive Health Specialists

_____ _____
Patient Name Printed Witness Name Printed

_____ _____ _____ _____
Patient Signature Date Witness Signature Date

F03-8/9/12