Robert C. Janda, MD
Robert M. Lee, MD
Peter L. Seraphin, DO
Erin L. Downes, PA-C

Hinsdale Gastroenterology Associates, SC
12 Salt Creek Lane, Suite 425
Hinsdale, IL 60521
ph 630/789.2260 fx 630/789.1584

COLON SCREENING PACKET

Dear Patient:

You contacted our office to schedule a screening colonoscopy. This packet contains the documentation required by your Physician prior to scheduling your procedure. The packet supplies the information normally obtained during an office consultation. If you prefer, you have the option of making an appointment to consult with the physician or physician assistant before scheduling your procedure.

This packet contains the following documents.

- **Patient Information/Signature Form** (2 pages):
  - **Page 1** provides your demographic information. Please complete all sections. Give us a telephone number where we may contact you during normal business hours for scheduling purposes.
  - **Page 2**: Initial each of the four sections and sign it at the box at the bottom of the form.
  - *** Note***: We must receive a copy of the front and back of your insurance card/s for scheduling purposes.
- **Medical History Form** (2 pages): This form replaces your medical encounter with a physician and must be completed in its entirety.
- **Colon Screen Waiver**: Some insurance companies do not pay benefits for colon screenings. Your dated signature is required.

If you have any questions while completing the packet, please contact our office. We must receive all required information, signatures and documents before we will be able to schedule your procedure. Once we receive your packet, a member of our medical staff will review it and a scheduler will contact you to schedule your colonoscopy appointment.

Sincerely,

The Physicians and Staff at Hinsdale Gastroenterology Associates

Hinsdale Gastroenterology Associates, SC

ROBERT C. JANDA, MD ROBERT M. LEE, MD
PETER L. SERAPHIN, DO ERIN DOWNES, PA-C
12 Salt Creek Lane, Suite 425
Hinsdale, IL 60521
Ph (630)789-2260 Fx (630)789-8540

PATIENT INFORMATION

NAME_____ TODAY'S DATE_____

BIRTHDATE_____ SEX: ☐ M ☐ F

ADDR_____ CITY/STATE_____ ZIP_____

Please place an "X" next to your primary contact number. ☐ HOME PHONE (_____)_____

☐ WORK PHONE (_____)_____ ☐ CELL PHONE (_____)_____

MARITIAL STATUS S M D SEP W IF MARRIED, SPOUSE'S NAME_____

EMERGENCY CONTACT_____ PHONE (_____)_____

REFERRING PHYSICIAN_____ PHONE (_____)_____

PHARMACY NAME_____ PHONE (_____)_____

ADDRESS_____ CITY/STATE_____ ZIP_____

INSURANCE INFORMATION

If we have scanned your insurance card or you have provided a copy of the front and back of your insurance card, you **do not** have to complete this section.

PRIMARY INSURANCE

INSURANCE CO NAME_____

POLICY/ID#_____

GROUP#_____

SECONDARY INSURANCE

INSURANCE CO NAME_____

POLICY/ID#_____

GROUP#_____

EMPLOYER INFORMATION

PATIENT'S EMPLOYER

NAME_____

ADDR_____

_____

PHONE (_____)_____

INSURED's EMPLOYER (If different from patient's employer)

NAME_____

ADDR_____

_____

PHONE (_____)_____

PHYSICIAN CHOICE: PLEASE CIRCLE ONE

DR. JANDA DR. LEE DR. SERAPHIN NO PREFERENCE

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SIGNATURE PAGE

PERSONAL MEDICAL HISTORY AND HEALTH FORM

I certify that I have given information that is complete, accurate, and current in the Hinsdale Gastroenterology Associates Personal Medical History and Health Questionnaire.

_____ **Initial**

NOTICE OF PRIVACY PRACTICES

Hinsdale Gastroenterology Associates, SC may use and disclose protected health information for treatment, payment and healthcare operations. Examples of these include, but are not limited to, referral to other providers for treatment, requested life insurance physicals, referral to nursing homes, home health agencies. Payment examples include, but are not limited to, insurance companies for claims including coordination of benefits with other insurers; collection agencies; pre-certification of treatment. Healthcare operations include, but are not limited to, internal quality control and assurance including auditing of records. Hinsdale Gastroenterology Associates, SC is permitted or required to use or disclose protected health information without the individual's written consent or authorization in certain circumstances. Our practice utilizes electronic verification of insurance eligibility and prescription benefits. At your request, a copy of our notice of privacy practices in its entirety is available for review. By signing below I acknowledge that I have been informed of Hinsdale Gastroenterology Associates, SC Notice of Privacy Practices.

_____ **Initial**

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize the release of any medical information to my insurance carrier requested and required to expedite the processing of my insurance claim/s for services rendered by Hinsdale Gastroenterology Associates. Furthermore, I authorize payment of the claim to the provider of said services: Robert C. Janda, MD, Robert M. Lee, MD, Peter L. Seraphin, DO. If my insurance carrier required that I obtain a referral form or pre-certification for any services requested, I understand that it is my responsibility to contact my insurance carrier or my primary care physician to obtain the appropriate authorization. I understand that I am financially responsible for charges incurred for services rendered. I am responsible for the co-insurance, co-pay, deductible or denial of coverage amounts according to the terms of my health insurance policy.

_____ **Initial**

MEDICAL RECORDS AND BILLING ISSUES

The following people are allowed to receive my medical information and discuss billing issues on my behalf.

	Records only	Billing only	Both
Name/s:_____ ☐ Spouse ☐ Parent/s ☐ Children ☐ Other	☐	☐	☐
Name/s:_____ ☐ Spouse ☐ Parent/s ☐ Children ☐ Other	☐	☐	☐

_____ **Initial**

PATIENT Signature Acknowledgement

X_____	_____	_____
Signature of Patient or Personal Representative	Relationship	Date
_____	_____	_____
Signature of Patient or Personal Representative	Relationship	Date

HINSDALE GASTROENTEROLOGY ASSOCIATES
12 SALT CREEK LANE SUITE 425 HINSDALE, ILLINOIS 60521 630-789-2260
Robert C. Janda, MD Robert M. Lee, MD Peter L. Seraphin, DO Erin L. Downes, PA-C

MEDICAL HISTORY

Date_____

Name _____ Birthdate _____ Age _____

Address _____ City, State_____ Zip Code_____

Home Phone _____ Number you can be reached at during the day _____

List the main reason for your visit. _____

Who referred you? Dr. _____

Please give us the names (first and last) of the doctors you are seeing.

Dr. _____ Dr. _____

Dr. _____ Dr. _____

Please list **ALL** of your medical conditions:

_____ _____ _____

_____ _____ _____

Please list **ALL** Surgeries:

Reason:	Year:

Please list any medications you are currently taking (dose and frequency). Include vitamins, aspirin or over the counter medicines.

_____ _____ _____

_____ _____ _____

_____ _____ _____

Are you allergic to any medications? Yes / No If yes, list medication and reaction _____

Are you allergic to latex ? Yes / No Are you allergic to IV contrast dye? Yes / No

Do you drink alcohol? Yes / No How many drinks per week? _____ Do you smoke? Yes / No

Height _____ft. _____in. Weight _____lbs

Family History: Please check any condition a blood relative has had.

	Y	N	RELATION/AGE		Y	N	RELATION/AGE
Colon Cancer				Inflammatory Bowel Disease (Crohn's or Ulcerative Colitis)			
Other Digestive System Cancers				Celiac Disease			
Polyps in the colon				Liver Disease			

REVIEW OF SYSTEMS

		YES	NO
GENERAL	Do you currently have a fever?		
EYES	Have you noticed recent changes in vision?		
	Do you have blurred vision?		
CARDIOVASCULAR	Do you have chest pain?		
	Do you have irregular heartbeats?		
	Do you have shortness of breath with exertion?		
RESPIRATORY	Do you have difficulty breathing?		
	Have you noticed any wheezing?		
GASTROINTESTINAL	Have you noticed a change in bowel habits?		
	Do you have constipation? Y /N Diarrhea Y / N		
	Do you have any nausea and/or vomiting?		
	Do you have jaundice?		
	Have you seen blood from the rectum? Volume: small medium large Frequency: daily weekly monthly		
	Have you passed black tarry stools recently?		
	Do you have difficulty or pain with swallowing?		
	Do you have acid reflux or heartburn more than twice a week?		
GENITOURINARY	Do you have discomfort when you urinate?		
	Do you have urgency to urinate?		
SKIN	Do you have a rash?		
	Do you have itching?		
NEUROLOGIC	Do you have numbness or tingling?		
	Do you have a history of seizures?		
MUSCULOSKELETAL	Do you have bone pain?		
	Do you have back pain?		
ENDOCRINE	Do you have trouble tolerating the heat?		
	Do you have trouble tolerating the cold?		
	Have you had significant weight loss in the last year? If yes, number of lbs. _____		
	Have you had significant weight gain in the last year? If yes, number of lbs. _____		
PSYCHIATRIC	Do you have anxiety ?		
	Do you have depression?		
HEME-LYMPH	Do you bleed easily?		
	Have you noticed lymph node enlargement or tenderness?		

Anything else you would like the doctor to know? _____

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Colon Screening Waiver

Date:_____

Patient:_____

Date of Birth:_____

I agree to pay for any and all medical services I receive from the providers of this practice. I realize that some insurance carriers do not pay benefits for colon screening office visits and colonoscopy procedures. This office will file a claim on my behalf. If my insurance company denies the claim for any reason (for example: non-covered services, does not pay for preventative medicine care, my failure to secure a referral from my primary care physician, etc.) I will be financially responsible for prompt payment upon notification of denial.

I further agree and understand that Hinsdale Gastroenterology Associates can only file a claim for my care with a diagnosis that is documented in my medical records. I understand that the office cannot change a diagnosis solely to ensure payment of the claim.

Signature:_____ Date:_____
Patient or Responsible Party (if a minor)