GATEWAY
GASTROENTEROLOGY

David D. Benage, M.D.
Jeffrey T. Kreikemeier, M.D.
Loren H. Marshall, M.D.
Jefrey E. Mathews, M.D.
Brian C. McMorrow, M.D.
Richard T. Riegel, M.D.
Andrew Y. Su, M.D.
Fred H. Williams, M.D.
Cheri M. Carmody, A.N.P.

(314) 529-4900 | WWW.GATEWAYGI.COM

COVER LETTER

Dear Patient,

Please fill out the enclosed pre-registration form and bring it with you to our office 15 minutes before your scheduled appointment. It would also be helpful if you could bring your insurance cards and driver's license with you so our office may have a copy in our records. Please note that it is your responsibility to know the rules of your insurance company. If a referral form is required, please be sure to obtain it and bring it with you. Unfortunately, we are not able to see you without the referral.

The doctor's office is located in St. Luke's Outpatient Center at 121 St. Luke's Center Drive, Suite 406, Chesterfield, MO 63017. It is on the west side of Highway 141/Woods Mill Road across from St. Luke's Hospital.

Please…help us out. If you are unable to keep your appointment, let us know **AS SOON AS POSSIBLE** – at least 48 hours ahead of time. Someone else will want to use this time.

If you have any questions regarding your visit, please feel free to contact the office.

This paperwork is required for your appointment. Please review the data already entered on the form and make corrections as needed. Your date of birth and social security number are not included to protect your identity. Please fill in you date of birth on each form that it is required. Your social security number is optional. Please sign and date the form including receipt of the Privacy Practice Notice. If you do not bring your paperwork with you to the appointment, you will be asked to fill it out again in the waiting room and this may delay your appointment. We appreciate your cooperation.

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WELCOME

Dear Patient:

Welcome to Gateway Gastroenterology! We look forward to meeting you. We'd like to take this opportunity to tell you a little about our practice.

Gateway Gastroenterology is a group of eight board-certified gastroenterologists that was established in 1984. Our areas of expertise include the esophagus, stomach, small intestine, colon, liver, gallbladder, and pancreas. We offer a wide variety of gastroenterology services including inpatient and outpatient consultation as well as a broad range of endoscopic procedures including screening colonoscopy, upper endoscopy, testing for dietary intolerance, etc.

Our goal is to provide outstanding care in a timely, courteous, and professional manner. All of our physicians are committed to ongoing education and will make every effort to provide you with the most up to date and thorough care possible.

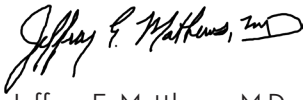
We will try hard to make your experience with us as hassle-free as possible. To this end, we will see you in a timely manner, return phone calls, and communicate with your other physicians.

Our practice includes a Board Certified Nurse Practitioner who is specialized in gastroenterology and assists us in seeing patients in the office. Through her work, we are able to provide greater office time availability and flexibility. In addition, she has been an educational resource to patients regarding digestive diseases as well as nutritional and lifestyle changes that may help resolve their GI problems. Our staff consists of friendly and knowledgeable people that are available to help with your scheduling, billing, and insurance needs.

We look forward to working with you.

Respectfully,

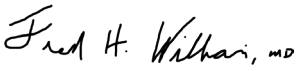

David Benage, M.D.


Jeffrey E. Matthews, M.D.


Andrew Y. Su, M.D.


Jeffrey T. Kreikemeier, M.D.


Brian C. McMorrow, M.D.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Loren H. Marshall, M.D.


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HOW DID YOU HEAR ABOUT OUR PRACTICE:

☐ Primary Care M.D. ☐ OB/GYN ☐ Internet ☐ Friend/Family ☐ Advertisement ☐ Other _____

NAME: MR./MRS./MS.		
STREET ADDRESS:		
CITY:	STATE:	ZIP:
SSN:	DOB:	
HOME PHONE NUMBER:	ALTERNATE NUMBER:	
EMPLOYER:	OCCUPATION:	
MARITAL STATUS:	SPOUSES NAME:	
EMERGENCY CONTACT:	RELATIONSHIP TO CONTACT:	

THE FOLLOWING IS REQUIRED BY THE STATE OF MISSOURI:

☐ Hispanic or Latino ☐ Neither Hispanic or Latino

RACE:

☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Island ☐ Other ☐ Multi-Racial (two or more races) ☐ Choose Not to Answer

MEDICAL INSURANCE INFORMATION

Primary Insurance Company	Phone Number
Policy/Id#	Group#
Relationship to policy holder	Policy Holder DOB
Secondary Insurance Company	Phone Number
Policy/Id#	Group#
Relationship to policy holder	Policy Holder DOB

Responsible Party

NAME: MR./MRS./MS.		
STREET ADDRESS:		
CITY:	STATE:	ZIP:
SSN:	DOB:	
HOME PHONE NUMBER:	ALTERNATE NUMBER:	
EMPLOYER:	OCCUPATION:	
RESPONSIBLE PARTY/GUARANTOR'S SIGNATURE		

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS/RECEIPT OF PRIVACY PRACTICES POLICY

I hereby authorize the release of any medical information necessary to process my health insurance claims and request payment of benefits to Gateway Gastroenterology, Inc for services rendered. I permit a copy of this authorization to be in place of the original. I understand that I am financially responsible to these providers of service for charges not covered or denied by my insurance company. I further agree in the event of my non-payment, to pay the cost of collection and/or court costs and reasonable fees should this be required.

I have received a copy of Gateway Gastroenterology, Inc.'s Notice of Privacy Practices

SIGNATURE _____ DATE _____ SIGNATURE _____ DATE _____

Gateway Gastroenterology, Inc. Medication Sheet

For Medical Records purposes, we will need you to provide us with a list of your current medications. This information is very important to us. Please complete this list below and bring it with you at the time of your appointment. Thank You!

Patient Name _____ Date of Birth _____
Date _____

Medication Allergies and Reactions

_____
_____

	Medication (Include non-prescription and herbal supplements)	**Dosage**	**Frequency (how often)**
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9.	_____	_____	_____
10.	_____	_____	_____

*If more space is needed, please continue on the back of this form.

Signature/Title/Date of RN Reviewing Medication List

_____

INFORMATION RELEASE

I _____ GIVE CONSENT FOR ANY MEDICAL
(Print Patient's Name Here)

INFORMATION TO BE RELEASED TO THE FOLLOWING PARTIES:

_____ RELATIONSHIP _____

_____ RELATIONSHIP _____

_____ RELATIONSHIP _____

_____ RELATIONSHIP _____

_____ RELATIONSHIP _____

IT IS THE PATIENT'S RESPONSIBILITY TO CONTACT THIS OFFICE IF ANY NAME LISTED ABOVE WOULD NEED TO BE REMOVED. A NEW CONSENT FORM WOULD NEED TO BE FILLED OUT.

_____

PATIENT SIGNATURE D.O.B

_____

DATE

_____

WITNESS

SIGNATURE
MEDICAL GROUP
PHYSICIANS MAKING A DIFFERENCE

SIGNATURE MEDICAL GROUP, INC.

Acknowledgment of Receipt of Notice of Privacy Practices

I, _____, have received a copy of Signature Medical Group, Inc.'s updated Notice of Privacy Practices.

_____
Signature of patient or parent/legal guardian/legally responsible person

_____
Description of relationship to the patient

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- □ Individual/Representative refused to sign the form
- □ An emergency situation prevented us from obtaining acknowledgement
- □ Other (Please Specify)

_____

_____

_____