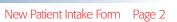


Yadkin Valley Gastroenterology

New Patient Intake Form



Name:	Spouse:		
Birth Date:	Social Security No:		
Address:			
Home Phone:			
Cell Phone:	Other Phone:		
Referred By:			
Insurance (BRING CARD):			
Allergies: (check all that apply) □ Codeine □ Bee Sting □ Sulfa Current Medications:	□Penicillin □C	Other:	
Name	Dose (mg)	How many times per day?	
Primary Care Physician Full Name:			
Address:			
Phone:	Fay:		



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What other doctors are you seeing?

Doctor	Why are you seeing him/her?	Location
Have you ever been hosp	italized or had surgical pro	cedures? Yes No
When	Where	Reason
Have you ever had a bloo	d transfusion? □Yes □]No
•	Reason:	
Please check any of these	products that you use:	
•	per day \square Snuff \square C	Thewing Tobacco
_	□ Spirits □ Other	_
		per day □ Tea glasses per day



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Lung Disease (emphysema/asthma):

Lung Cancer:

Other:

Please circle any illnesses or health problems you may have or have had.

Trease circle arry filliesses of fi	ealth problems you may have of h	ave nau.
Heart Attack	Seizure/Epilepsy	Diabetes Mellitus
Stomach Ulcers	Hiatal Hernia	Stroke
Colon Cancer	Breast Cancer	Lung Cancer
Asthma	Emphysema	Tuberculosis
High Blood Pressure	Elevated Cholesterol	Arthritis
COPD	Anemia	Migraines / Severe Headache
Glaucoma	Thyroid Disease	Hepatitis
Kidney Disease	Cirrhosis	Cold / Productive Cough
Please circle any family illnesses. List the relatives using the Heart Surgery: Seizure/Epilepsy: Stroke: Breast Cancer: Colon Cancer: High Blood Pressure: Elevated Cholesterol:		M = Mother F = Father B = Brother S = Sister A = Aunt U = Uncle MGM = Maternal Grandmothe PGM = Paternal Grandfather PGF = Paternal Grandfather
Stomach Ulcers:		
Arthritis:		
Tuberculosis:		
Heart Attack:		
Diabetes:		



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New Patient Intake Form Page 4

Emergency Contact Information Name of person **not living with you**_____ Relationship Home Phone: Work Phone: Name of person **not living with you**_____ Relationship_ Home Phone:_____ Work Phone:____ **Assignment of Benefits:** I hereby assign payment directly to Yadkin Valley Gastroenterology of the medical and/or major medical benefits, if any, otherwise payable to me pursuant to the terms of any insurance policy for services rendered. Release of Information: I hereby authorize Yadkin Valley Gastroenterology to release such medical information as may be required by any insurance company concerned with payment of benefits for me. I further authorize Yadkin Valley Gastroenterology to release medical information to any facility or physician to whom I am referred. These authorizations shall remain in effect until I provide written notice revoking them. **Authorized Recipient of Information:** I hereby authorize Yadkin Valley Gastroenterology to discuss my health condition with (name) (relationship) (relationship) (name) (name) (relationship) Signature of patient or responsible party Date **Privacy Notice:** I acknowledge that I have received the Yadkin Valley Gastroenterology Privacy Notice as required by the Health Insurance Portability and Accountability Act (HIPPA). Signature of patient or responsible party Date