Welcome to Bay Area Gastroenterology Associates. We look forward to caring for you. To better serve you, please complete the information below..

Patient name: _____

Marital Status: Single Married Divorce Widowed Separated Partnered

Street: _____ City: _____ State_____ Zip_____

Home #: ( ) _____ Cell # ( ) _____Work #: ( ) _____

Date of Birth: _____ Email: _____

Social security Number ☐☐☐ — ☐☐ — ☐☐☐☐

Primary Care Physician: _____

Who referred you to our practice?_____

Emergency Contact: Name_____Phone # ( )_____

Address_____Relationship_____

Pharmacy _____ Pharmacy Phone Number: _____

Person who is responsible for insurance account (person who holds the insurance policy or legal Guardian of a minor)

Last Name_____First Name_____Middle Initial__

Home Phone # ( ) _____ Work Phone# ( ) _____Ext._____

Relationship to patient_____ Date of Birth (mm/dd/yyyy) ___/___/_____

Gender: M F Employer: _____ Occupation: _____

Social security Number ☐☐☐ — ☐☐ — ☐☐☐☐

1818 Short Branch Drive, ste 102
Trinity, FL 34655
Phone 727-372-4500
Fax 727-372-3500

Primary Insurance

Company: _____

Insured's Name: _____ Date of Birth: _____

Relationship to Patient: _____

ID #: _____ Group #: _____

Secondary Insurance

Company: _____

Insured's Name: _____ Date of Birth: _____

Relationship to Patient: _____

ID #: _____ Group #: _____

Patient Signature _____
Date: _____

Please initial if you authorize us to leave a voicemail on the number provided regarding appointment time

_____ No

_____ Yes

1818 Short Branch Drive, ste 102
Trinity, FL 34655
Phone 727-372-4500
Fax 727-372-3500

Patient Name: _____ Date of Birth: _____

Chief Complaint: _____

List of current Medication or attach list:

1._____ 2._____ 3._____ 4._____

5._____ 6._____ 7._____ 8._____

Medical History

☐ Hypertension ☐ Stroke ☐ Diabetes ☐ Heart Disease

☐ CHF ☐ Asthma ☐ Depression ☐ Hypothyroidism

☐ Enlarged Prostate ☐ Angina ☐ Emphysema ☐ High Cholesterol

☐ Seizure ☐ Arthritis ☐ COPD ☐ Hyperthyroidism

☐ Cancer: _____ ☐ Other (s): _____

Allergies

1.	4.	7.
2.	5.	8.
3.	6.	9.

Past Surgical History *(check all that applies)*

☐ Heart Catheterization ☐ Gallbladder Surgery ☐ Open Heart Surgery

☐ Appendix Surgery ☐ Other Surgeries: _____

Have You ever had a colonoscopy? **Y** or **N** if yes, when? _____ Physician: _____

Family History

	Mother	Father	Siblings	Children	Grandparents
Stroke					
Hypertension					
Heart Disease					
Colon Cancer					
Colon Polyps					
Crohn's Disease/ Ulcerative Colitis					
Other:					

1818 Short Branch Drive, ste 102
Trinity, FL 34655
Phone 727-372-4500
Fax 727-372-3500

Social History (*circle)*

Have you ever smoke? **Y** or **N** Do you currently smoke? **Y** or **N** If yes, How much? _____

Do you drink alcohol? **Y** or **N** If yes, How much? _____ How often? _____

Any history of illicit drugs? _____

Office Use Only:

Weight:	Height:	Blood Pressure:	Heart Rate:

1818 Short Branch Drive, ste 102
Trinity, FL 34655
Phone 727-372-4500
Fax 727-372-3500

Authorization for Treatment/Release of Information

Consent to Treatment: The patient and/or authorized representative do hereby consent to any and all medical treatment which may deem advisable by the physician(s) of Bay area Gastroenterology Associates (BAGA).

Authorization for Release of Confidential Information: I hereby authorize Bay area Gastroenterology Associates (BAGA) to release medical information contained in my/the patient's records to any insurance carrier, employer or other third party intermediary utilized by the patients for the purpose of obtaining information and/or reviewing the record of medical care received by the patient for the payment of all medical charges. Copies of records may also be sent to referring physicians for continuity of care. Medical Records released may include any diagnostic or therapeutic information of visits and/or procedures performed in office. Unless initiated below the records may not include any confidential information regarding
_____Alcohol/Substance Abuse _____Mental Health _____HIV

According to the Health Insurance Portability and Accountability Act of 1996(HIPAA):
The patient's medical record may not be furnished to and the medical condition of the patient may not be discussed with any other person than the patient, the patient's legal representative, or other health care practitioners involved in the care and treatment of the patient without the patient's written authorization. The patient may at this time authorize and individual to be actively involved in the patient's information as mention above.

Name: _____Relationship_____

Medicare Patients: I certify that the information given by me in applying got payment under title xvii of the Social Act is correct. I authorize Bay area Gastroenterology Associates (BAGA) to release any information needed for this or related Medicare claim to the Health Care Financing Administration or its carriers or intermediaries. I hereby authorize payment directly to Bay area Gastroenterology Associates (BAGA) for medical benefits otherwise payable to me as a beneficiary of the Medical Program and such other payments as may be due by other third party payers. I agree to execute such documents as may be necessary to apply for and obtain payment. I understand that such services as, but not limited to, routine testing may not be covered by Medicare unless the physician provides medical necessity.

1818 Short Branch Drive, ste 102
Trinity, FL 34655
Phone 727-372-4500
Fax 727-372-3500

Assignment of Insurance Benefits: I assign payment directly to Bay area Gastroenterology Associates (BAGA, the insurance benefits otherwise payable to me. I understand that I am financially responsible for charges not paid by this assignment, I will assist in the collection of my insurance should there be any delay in payment. I agree to actively pursue collecting insurance payment for any claims unpaid after (30) days. In after forty-five (45) days the claim remains unpaid, I understand the balance will be due from me.

Pre-Authorization: Your insurance company may require pre-authorization for office visits and/or procedures. I understand that if proper authorization is not obtained from my PCP (Primary Care Physician) I will be liable for charges incurred.

Patient/Guarantor Agreement: I understand that Bay area Gastroenterology Associates (BAGA is not the business of extending credit. Therefore, it is the policy of Bay area Gastroenterology Associates (BAGA to require payment in full at the time of service. If unable to pay patient due balance in full at the time of service, I agree to make prior arrangements with the billing department.

I understand that I am financially responsible for my/the patient's account with Bay area Gastroenterology Associates (BAGA, regardless of my insurance benefits. I authorize a copy of this form to be valid as the original.

Patient/Responsible Party: _____ Date: _____

1818 Short Branch Drive, ste 102
Trinity, FL 34655
Phone 727-372-4500
Fax 727-372-3500

PATIENT PORTAL AUTHORIZATION FORM

Our patient portal lets established patients communicate more easily with us. The portal is not intended for "Web Visits" or new problems. Instead, it will make regular communication more flexible. The portal is a voluntary option and is free of charge to all patients. The patient portal provides you with a much more seamless way to access your health information and contact our office.

Through the portal, you can:

- Request refills
- Update your contact and insurance information
- Check your medication list, medical history and your visits
- Get your lab results quickly

Privacy matters. We will never sell/trade/abuse your email address. The patient portal is protected just like all other interactions with our office. We also think it's important for you to protect privacy on your end, and we recommend that you protect your user name and password to avoid misuse.

We take security seriously, too. Computer networks do have real risks. We use appropriate technologies to protect your health information. We follow all security laws, including HIPAA and HITECH.

Bedside manner is complicated via email. It's easy to misread information or emotion. We'll try to keep things brief and clear on the Portal. We really appreciate your help on that, too. If a message takes a long time to write, it's probably something better done in person at an office visit.

We want your records to be complete and correct. Let us know if there's any problem with your records. Sometimes we may use medical jargon in your records and it can lead to confusion, if something doesn't make sense, let us know.

If we have troubles, abuse or 'Spam', we may need to change policies, suspend accounts, or even terminate the portal.

You can access the portal day or night, but we don't have a 24 hour presence on our end. As a safeguard, the portal should not be used for pressing issues. If you are experiencing an emergency or have an urgent medical need, you should call our office. If it's after hours, we recommend that you go to **Urgent Care**, the **emergency room** or call **911.**

By signing below, I understand there are pros and cons to using the patient portal for communications with the clinic. I have had a chance to discuss my concerns with the office and have my questions answered.

By signing below, I acknowledge that I would like a Patient Portal account and agree to the terms and conditions set forth above.

Signature:_____ Print Name:_____
E-mail address_____

1818 Short Branch Drive, ste 102
Trinity, FL 34655
Phone 727-372-4500
Fax 727-372-3500