**Montgomery Gastroenterology, P.A.**
**12012 Veirs Mill Road**
**Silver Spring, MD 20906-4513**
**Tel. (301) 942-3550 Fax (301) 933-3621**
**www.montgomerygastro.com**

Today's Date:_____/_____/_____.

Patient Name Last:__________________________ First:______________________________ M.I:___________

Birth Date:_____/_____/_____ Sex- F M Reason for Today's Visit: _________________________________

Referring Physician: _____________________ Primary Care Physician: ________________________________

Date of your last physical exam: _____/_____/_____ Other Physicians: ________________________________

## PAST MEDICAL HISTORY

None
Anemia
Asthma
Atrial Fibrillation
Bleeding Tendencies
Breast Cancer
Congestive Heart Failure
COPD
Depression
Diabetes
Heart attack
Heart murmur
High Blood Pressure
HIV/AIDS
High Cholesterol
Kidney Disease/Failure
Leukemia

Lupus
Osteoarthritis
Paralysis
Parkinson's
Seizures
Skin Cancer
Sleep Apnea
Stroke
Thyroid Disorders
Tuberculosis
Other:__________________

_______________________

_______________________

**G.I Conditions:**
Acid Reflux
Cirrhosis
Colon Polyps
Colon Cancer
Crohn's Disease
Diverticulitis
Fatty Liver
Gallstones
Hepatitis A/B/C
Irritable Bowel (IBS)
Pancreatitis
Stomach/Duodenal Ulcers
Ulcerative Colitis
Swallowing difficulty

## PRIOR SURGERIES

None
Appendix
Cardiac Surgery
Colon

C-Section
Groin Hernia
Hysterectomy
Obesity Surgery

Tonsils
Uterus/Ovary
Other

________________________________________________________________________________________________
_

Prior Endoscopic Procedures i.e., Colonoscopy, Upper endoscopy, ERCP (please list year)

________________________________________________________________________________________________

## VACCINATIONS

| | Yes/No | Year |
|---|---|---|
| Flu | ________________ | __________________ |
| Hepatitis A | ________________ | __________________ |
| Hepatitis B | ________________ | __________________ |
| Pneumococcal | ________________ | __________________ |

## MEDICATIONS

Prescriptions

Over the counter (OTC)

_________________________________
_________________________________________

_________________________________
_________________________________________

_________________________________
_________________________________________

_________________________________
_________________________________________

_________________________________
_________________________________________

## ALLERGIES

None Latex Versed Demerol
Propofol Iodine/I.V. Contrast Sulfa Penicillin
Morphine Codeine Aspirin Other________________
Eggs

## FAMILY HISTORY

Colon cancer Colonic Polyps Ulcerative Colitis Crohn's Disease
Liver disease Pancreatic Cancer Liver Cancer Esophageal Cancer
Celiac Disease Gallstones Barrett's Esophagus Irritable Bowel Syndrome
Stomach Cancer Ovarian Cancer Uterine Cancer
Other ______________________________________________________________________________

## SOCIAL HISTORY

**Personal Habits:**
Never smoked tobacco
Former smoker Year of tobacco cessation: _____________
I currently smoke Number of cigarettes/packs per day Years of use:_________

Alcohol- never Alcohol- occasional

Alcohol- daily    Prior alcoholic

Never used illicit drugs    Prior illicit drug use    Current illicit drug use

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## PATIENT INFORMATION

Last name:_________________________________ First Name:______________________________ M.I.:_____

Date of Birth:_____/_____/_____ Social Security #:_____________________ Place of Birth:______________

Address:______________________________________________________________________________________

City:_____________________ State: __________ Zip code: _________ County: _________________________

Home phone: (____) ______________ Daytime phone: (____) ________________ Cell: (____) ____________

E-mail:____________________________________ Languages Spoken: _________________________________

Race: __________________________________________ Ethnicity: ____________________________________

Married    Single  Separated    Divorced    Widowed Domestic Partner

Employer Name:__________________________________ Occupation: _________________________________

Pharmacy Address/phone number: ______________________________________________________________

***If referred by another doctor other than your primary care doctor fill in all information below***

**Primary Care Doctor**   Name:____________________________ Phone:________________________________

Date last seen:_______________________________ Address:_________________________________________

****************************************************************************************************
*

**Referring Doctor**   Name: _____________________________ Phone:________________________________

Date last seen:________________________________ Address:________________________________________

## EMERGENCY CONTACT

Last Name:___________________________ First Name:____________________ Relationship:_____________

Address:______________________________________________________________________________________

Home phone (____) ________________ Daytime phone (____) ________________ Cell (____) ____________

*****************************************************************************************
*

Do you have a D.N.R. (Do Not Resuscitate) order: Y _____ N _____

Do you have a Living Will: Y_____ N ______

## INSURANCE INFORMATION

**Primary Insurance Company**: ____________________________________________ Phone: _______________________

Address: _______________________________________________ City: ___________ State: _____ Zip code: __________

I.D #: ____________________________________________________ Group #: ___________________________________

Policy Holder: __________________S.S. # :______________Sex:_____ DOB:_________ Relationship:______________

**Secondary Insurance Company**: __________________________________________ Phone: _______________________

Address: _______________________________________________ City: ___________ State: _____ Zip code: __________

I.D #: ____________________________________________________ Group #: ___________________________________

Policy Holder: __________________S.S. # :______________Sex:_____ DOB:_________ Relationship:______________

## RESPONSIBLE PARTY STATEMENT

As the responsible party, I understand and agree that any and all charges that are not directly paid by my insurance company will be my responsibility if it is later determined that I am not eligible for benefits through my insurance carrier. It is known that all co pays and/ or deductible amounts are due and payable at time services are rendered.

I understand that if my insurance plan requires a referral form my Primary Care physician and I have not obtained on I agree to accept responsibility for payment to the doctor for services I receive should there be problems in my obtaining the aforementioned referral. I further agree to be responsible for any and all costs incurred by the doctor to obtain payment for services provided, that are not covered by my insurance company.

___________________________________________________ ________________________________________

Responsible Party Signature Date

## ASSIGNMENT OF BENEFITS & MEDICAL RELEASE AUTHORIZATION

I hereby authorize Montgomery Gastroenterology/Montgomery Endoscopy to apply for direct payment of benefits on my behalf from my insurance carrier for covered services rendered by David B. Doman, M.D. and Sindu Stephen, M.D.

I certify that the information that I have provided with regards to my insurance coverage is correct. I further authorize release of information as known to the doctor for this or any related claims to my insurance carrier. I permit a copy of this authorization to be used in place of an original for any such requests. At any time, either my insurance company or myself may revoke this authorization in writing.

___________________________________________________ ________________________________________

Responsible Party Signature Date

___________________________________________________ ________________________________________

Responsible Party Signature Date

## RELEASE OF MEDICAL INFORMATION

Messages can be left on my cell-phone, answering machine or voicemail regarding my medical care.

The following persons are allowed to discuss my medical care with my physician, this can be changed by me with the proper written request.

_______________________________________________________________________________________

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___________________________________ ___________________________

Signature Date