Insurance cards copied ☐
Date: _____

Patient Registration Information

Account # _____
Insurance # _____
Co-Payment: $ _____

Please PRINT and COMPLETE ALL sections below!

Is your condition a result of a work injury? YES NO An auto accident? YES NO Date of injury: _____

PATIENT'S PERSONAL INFORMATION Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
First & Last Name: _____ Middle Initial _____ Sex: ☐ Male ☐ Female
Street Address: _____ (Apt # ____) City: _____ State: _____ Zip: _____
Home phone: (___) _____ Email Address: _____ Social Security # _____-_____-_____
Date of Birth: _____/_____/_____ Driver's License: (State & Number) _____
Employer/Name of School _____ ☐ Full Time ☐ Part Time
Spouse's Name: _____ Spouse's Work phone (____) _____
How do you wish to be addressed? _____ Social Security # _____-_____-_____

PATIENT'S / RESPONSIBLE PARTY INFORMATION
Responsible party: _____ Date of Birth: _____
Relationship to Patient: ☐ Self ☐ Spouse ☐ Other _____ Social Security # _____-_____-_____
Responsible party's home phone (____) _____ Work phone: (____) _____
Address: _____ (Apt # ____) City: _____ State: _____ Zip: _____
Employer's name: _____ Phone number: (____) _____
Address: _____ (Apt # ____) City: _____ State: _____ Zip: _____
Your occupation: _____
Spouse's Employer's name: _____ Spouse's work phone (____) _____
Address: _____ (Apt # ____) City: _____ State: _____ Zip: _____

PATIENT'S INSURANCE INFORMATION Please present insurance cards to receptionist.
PRIMARY Insurance company's name: _____
Insurance address: _____ City: _____ State: _____ Zip: _____
Name of insured: _____ DOB: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Other ☐ Child
Insurance ID # _____ Group number: _____
Check if appropriate: ☐ Medigap policy ☐ Retiree coverage

PATIENT'S REFERRAL INFORMATION
Referred by: _____ If referred by a friend, may we thank her or him? YES NO
Name(s) of other physician(s) who care for you: _____

EMERGENCY CONTACT
Name of person not living with you: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone number (home): (____) _____ Phone number (work): (____) _____

Assignment of Benefits – Financial Agreement

I hereby give lifetime authorization for payment of insurance to be made directly to _____, and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.
I further agree that a photocopy of this agreement shall be as valid as the original.

Date: _____ Your Signature: _____
Method of payment: ☐ Cash ☐ Check ☐ Credit Card

SINGARAM GASTROENTEROLOGY
Reassurance. Relief. Recovery.

1905 W. 57th Street, Sioux Falls, SD 57108
Phone: 605-310-2000
Fax: 605-274-1919

Patient History Form

Name:_____ Date of Birth:_____ Today's Date:_____

Referring Physician:_____ Primary Care Provider:_____

Reason for your visit today:_____

Pharmacy Name and Location:_____

Please indicate if you have had any of the following symptoms in the past 30 days:

- ☐ No symptoms
- ☐ Acid reflux
- ☐ Abdominal pain
- ☐ Abdominal bloating
- ☐ Recent weight changes
- ☐ Nausea
- ☐ Vomiting
- ☐ Fatigue
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal cramping
- ☐ Blood in the stool
- ☐ Fecal incontinence
- ☐ Belching or gas
- ☐ Other:_____

Please List all Medications You Currently Take:

(Include over the counter medication and supplements)

1._____ Dose:_____ Reason:_____
2._____ Dose:_____ Reason:_____
3._____ Dose:_____ Reason:_____
4._____ Dose:_____ Reason:_____
5._____ Dose:_____ Reason:_____
6._____ Dose:_____ Reason:_____
7._____ Dose:_____ Reason:_____
8._____ Dose:_____ Reason:_____
9._____ Dose:_____ Reason:_____
10._____ Dose:_____ Reason:_____

List all Medication Allergies:_____

Date of Last Colonoscopy/EGD:_____ Any Abnormal Findings?:_____
Which Facility was Used?:_____

Past Surgical History (include dates):_____

List all Current Medical Diagnoses:_____

SOCIAL HISTORY

Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced Who lives with you?_____

Gender ☐ Male ☐ Female

Employer / Occupation_____ What type of work?_____

Do you drink alcohol?_____ How many drinks per week?_____

Do you or have you ever used tobacco or nicotine products?_____ What is your current usage/frequency?_____

Quit Date for Previous Tobacco Users:_____

FAMILY MEDICAL HISTORY

Please List Medical Conditions for Immediate Family Members

Mother:_____ Father:_____

Brothers/Sisters:_____

Family Illnesses:

History of Colon Polyps or Colon Cancer: ☐ Mother ☐ Father ☐ Brothers/Sisters Age of Onset_____

History of Heart Disease? ☐ Yes ☐ No History of high blood pressure? ☐ Yes ☐ No

History of strokes? ☐ Yes ☐ No History of Diabetes? ☐ Yes ☐ No

Does anyone in the family have history of esophageal, stomach, pancreas, gall bladder, intestines, or liver cancers?
If yes, please describe:

Reassurance. Relief. Recovery.

HIPAA ACKNOWLEDGEMENT

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. As stated in our notice, the terms of the notice may change. If we change our notice, you may obtain a revised copy by contacting the Privacy Official at Gastroenterology – A Division of Midwest Medical Care.

By signing this form, you acknowledge that you have received a copy of our Notice of Privacy Practices dated April 14, 2003.

Name of Patient: _____
Print or Type

Date of Birth: _____

Patient or Patient Representative: _____
Signature

Date: _____

MIDWEST MEDICAL CARE, PC

DISCLOSURE OF OWNERSHIP INTEREST - SIOUX FALLS SPECIALTY HOSPITAL NOTICE TO PATIENTS

As a prospective patient at Sioux Falls Specialty Hospital, it is important that you read and understand the following disclosure prior to scheduling any procedure at the Sioux Falls Specialty Hospital. If you have any questions, please feel free to speak with your physician or a member of the staff at the Sioux Falls Specialty Hospital:

DISCLOSURE OF PHYSICIAN OWNERSHIP

1. The Sioux Falls Specialty Hospital is partially owned by physicians and meets the federal definition of a physician owned hospital as specified in 42 CFR 489.3.

2. Your physicians and/or the physician's immediate family members have the following ownership interest in the Sioux Falls Specialty Hospital: 1.5%

3. You have the right to choose the provider of your health care services. Therefore, you have the option to use a health care facility other than the Sioux Falls Specialty Hospital.

4. You will not be treated differently by your physician if you choose to use a different facility. If desired, your physician can provide information about alternative providers.

If you have any questions regarding the information contained in this Notice to Patients, please feel free to ask your physician or a representative of the Sioux Falls Specialty Hospital.

Acknowledgment of Disclosure

By signing this Acknowledgment of Disclosure, you acknowledge that you have read and understand the foregoing Notice to Patients regarding physician ownership.

_____	_____
Signature of Patient	Signature of Parent or Guardian (if applicable)
_____	_____
Print Name of Patient	Print Name of Parent or Guardian (if applicable)
_____	
Date	