

***Digestive Health Associates of Texas, P.A.***

PATIENT UPDATE INFORMATION (Dr. Luk)

(Fax 817-267-5601)

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

Reason for Visit/Procedure \_\_\_\_\_

Primary Physician (or Referring Physician if different) \_\_\_\_\_

(Circle appropriate answer – including YES or NO - for all questions and list details in the blanks or on separate page)

General health is Excellent / Very good / Good / Fair / Poor LAST COLONOSCOPY DATE (or None) \_\_\_\_\_

Number of drinks per week \_\_\_\_\_ Number of cigarettes (cigars / pipes / snuff) per day \_\_\_\_\_

LIST ALL KNOWN ALLERGIES, OR STATE NONE:

LIST ALL MEDICATIONS, PRESCRIPTION AND NON-PRESCRIPTION, OR STATE NONE:

SINCE YOUR LAST VISIT, HAVE YOU HAD ANY OF THE FOLLOWING ? Detail any Yes answers.

Hospitalizations Yes/No Surgeries Yes/No Emergency Room visits Yes/No Prolonged illness Yes/No

Frequency of BM's: 2-3 a day / 1 a day / 1 every 2 – 3 days / 1 every week / less than 1 a week

Use laxatives at least 1 a week Yes/No Use fiber supplements Yes/No Which one?

DO YOU HAVE ANY OF THE FOLLOWING? (Circle condition and describe) or Circle NONE

Pacemaker / Defibrillator

Nerve stimulator / Pain pump

Blurred vision / Eye pain

Heart bypass / cath / stents

Heart disease / Heart condition

High blood pressure

Congestive heart failure

Emphysema / Asthma

Sleep apnea / CPAP

Reflux / Heartburn / GERD

Kidney disease / Kidney stones

Difficulty with sedation / anesthesia

Arthritis / Joint Replacement

Fibromyalgia / Rheumatic diseases

Stroke / Seizure

Depression / Psychiatric diseases

Diabetes / Thyroid diseases

Easy bleeding / Easy bruising

Cancers / Transplants

AIDS or HIV

Immune diseases

Hepatitis / Liver diseases

Rectal bleeding / Blood in stools

**Family history colon cancer / colon polyp**

Patient signature \_\_\_\_\_ Date \_\_\_\_\_



PATIENT INFORMATION

Date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Who referred you to us? \_\_\_\_\_
PCP/Internist: \_\_\_\_\_

Name: \_\_\_\_\_ Birth date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Age \_\_\_\_ Sex: M/F

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home Phone# ( ) \_\_\_\_\_ Work Phone# ( ) \_\_\_\_\_ Cell Phone# \_\_\_\_\_

Social Security# \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Marital Status: (circle one) Single Married Divorced Widowed

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Patient's Occupation: \_\_\_\_\_

Name of Spouse: \_\_\_\_\_ Spouse SS#: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Birth date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Spouse Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Spouse's Occupation: \_\_\_\_\_

Spouse Work Phone#: \_\_\_\_\_ Spouse Cell Phone#: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone#: \_\_\_\_\_

Reason for Office Visit: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Claim Form Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Insured's ID#: \_\_\_\_\_ Group#: \_\_\_\_\_ Phone#: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Birth date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Insured's ID#: \_\_\_\_\_ Group#: \_\_\_\_\_ Phone#: \_\_\_\_\_

Pharmacy Name/ Address \_\_\_\_\_ Phone # \_\_\_\_\_

I understand that if any of the insurance information I have provided is incorrect or if I fail to notify the office of any insurance changes, that I am responsible for all physician charges and non-covered medical services.

I hereby authorize the release of any medical information necessary for the process of insurance. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled to DIGESTIVE HEALTH ASSOCIATES OF TEXAS, P.A. and DIGESTIVE HEALTH MANAGEMENT ENDOSCOPY CENTERS. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I have received the Notice of Privacy Practices.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**Consent for Medical Treatment**

I, the undersigned, the patient (or the patient's duly authorized representative) do hereby voluntarily consent to and authorize medical care encompassing all diagnostic and therapeutic treatments considered necessary or advisable in the judgment of the physician, his assistants or designees.

I am aware that the practice of medicine and surgery is not an exact science and acknowledge that no guaranties have been made to me as to the result of treatment or examinations performed.

I authorize Digestive Health Associates of Texas, P.A. or staff to retain, preserve and use for scientific or teaching purposes, or dispose of at their convenience and in their sole discretion any specimens or tissues removed and I waive any interest I may have had in such specimen tissues.

This form has been fully explained to me and I certify that I understand and accept its contents.

All the above will be discussed with me, by the attending physician prior to any proposed testing or any type of surgical procedures to be scheduled.

Patient's signature: \_\_\_\_\_

Date: \_\_\_\_\_



**7.30 Patient Authorization for Personal Representative**

Please print all information, then sign and date form at bottom.

**Type of Authorization:** Personal Representative

**Patient's name** (Please print): \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Purpose of request:** I authorize Digestive Health Assoc. of Texas, P. A. to disclose or provide my protected health information (PHI) to the following individual who is authorized to act as my personal representative for the purposes of receiving all PHI about myself. As my designated personal representative, they may exercise my right to inspect copy and correct my PHI. They may also consent or authorize the use or disclosure of my PHI:

\_\_\_\_\_  
Name of Personal Representative and Relationship (i.e. Spouse, family member, etc)  
\_\_\_\_\_  
Address  
\_\_\_\_\_  
City, State, Zip  
\_\_\_\_\_  
Phone

**Description of information to be disclosed** – I authorize Digestive Health Assoc. of Texas, P.A. to disclose all of my PHI to my designated personal representative.

**Circle one:**                      Procedure & Biopsy                      Labs                      All Information

**Expiration or termination of authorization** – This authorization will remain in effect until terminated by patient, the patient's personal representative, or another individual of legal entity authorized to do so by court order of law.

**Right to revoke or terminate** – As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in person or by mailing a request to:

DIGESTIVE HEALTH ASSOCIATES OF TEXAS, P.A.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
ATTN: \_\_\_\_\_

**Redisclosure** – We have no control over the person (s) you have listed as your personal representative. Therefore, your PHI disclosed under this authorization, will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of Digestive Health Assoc. of Texas, P.A.

**7.34 Patient Authorization for Disclosure of Protected Health Information via telephone.**

**Type of Authorization:** Telephone Contact

**Patient's name** (Please print): \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Purpose of request** – I authorize Digestive Health Assoc. of Texas, P.A. to disclose my PHI in the following manner:  
**(Check the box that applies)**

- Leave detailed messages on my answering machine/ voice mail
- Leave messages with only call-back number (includes staff member name and doctor's office) on my answering machine/voice mail
- Home Telephone: \_\_\_\_\_                       Cell Number: \_\_\_\_\_
- Work Telephone \_\_\_\_\_

**Expiration or termination of authorization** – This authorization will remain in effect until terminated by patient, the patient's personal representative, or another individual of legal entity authorized to do so by court order of law.

**Right to revoke or terminate** – As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in person or by mailing a request to:

DIGESTIVE HEALTH ASSOCIATES OF TEXAS, P.A.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
ATTN: \_\_\_\_\_

X  
\_\_\_\_\_  
Patients Signature

\_\_\_\_\_  
Date