Gastroenterology Consultants, PC

Please fill the paperwork out completely, include a copy of the front and back of current insurance cards and return to our office to be processed. Once the completed paperwork AND insurance information is received and reviewed, you will be contacted to schedule the appropriate appointment.

If it is being recommended that you should come back sooner than ten years due to a Person or Family history of Colon Cancer or Colon Polyps, please check with your Insurance as to their coverage guidelines.

We are contracted with most major insurance carriers. If you have coverage or copay questions, please contact your insurance with these questions and let them know we are a Specialist office.

If your insurance is a managed care plan (Allcare Advantage, some Oregon Health Plans, VA/Triwest, Providence Choice or Providence Connect) contact your primary care physician prior to making this appointment. Your Insurance requires an authorization to be in place before you can be seen in our office. This must be requested by your Primary Care doctor.

If you **do not** have Insurance you will need to pay a **$610 deposit** towards your procedure. You will need to pay your deposit for any services prior to scheduling. Please ask to meet with our billing department for any questions.

We do ask that if you are unable to keep your appointment, call our office 48 business hours prior to your appointment. Our normal business hours are Monday thru Thursday 8:00am to 5:00pm our number is 541-779-8367 option 1.

We look forward to seeing you!

Sincerely,
Gastroenterology Consultants

Gastroenterology Consultants, P.C .

Patient Name: **Date of Birth:**

Referring Physician: Primary Care Provider:

May we send a report to your physician? Yes ☐ No ☐

What is your chief complaint for today's visit?

ALLERGIES: Are you allergic to any medication: Yes ☐ NO☐ If yes please list medication and the reaction:

_____

Have you had the Influenza Vaccine Yes ☐ No ☐ **Date:** _____
Pneumonia Vaccine Yes ☐ No ☐ **Date:** _____

Has anyone in your Immediate FAMILY had any of the following? ☐ **None**

	Who/Age?		Who/Age?
☐	Chronic Acid Reflux	☐	Liver Disease
☐	Colitis	☐	Pancreatic Cancer
☐	Colon Cancer	☐	Pancreatic Disease
☐	Colon Polyps	☐	Stomach Cancer
☐	Crohn's Disease	☐	Ulcer Disease
☐	Gallstones	☐	Other Cancer (type)?

Please list any past procedures and/or radiology tests you have had. ☐ **None**

	Date/Where:		Date/Where:
☐	Barium Enema	☐	Small Bowel Series
☐	Colonoscopy	☐	Ultrasound
☐	CT Scan	☐	Upper Endoscopy
☐	Liver Biopsy	☐	Upper GI Series
☐	Sigmoidoscopy	☐	Others, please list:

Please list any previous surgeries you have had. ☐ **None**

	Date/Where:		Date/Where:
☐	Appendix	☐	Hysterectomy Vaginal or Abdominal
☐	Colon	☐	Small Bowel
☐	Esophagus	☐	Cesarean
☐	Gallbladder	☐	Others, please list:
☐	Heart	☐	Others, please list:

Personal Habits:

Alcohol	Yes ☐	No ☐	# per day?
Coffee	Yes ☐	No ☐	# per day?
Cola/Soda	Yes ☐	No ☐	# per day?
Illegal Drug Use	Yes ☐	No ☐	Type:
Marijuana	Yes ☐	No ☐	

Tobacco:

☐ Never
☐ Former: year/age quit
☐ Current ___# per day cigarettes/chew/pipe/cigar

Please mark below conditions you have had? OR Check here ☐ if NONE apply

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Autoimmune Hepatitis
- ☐ Blood Transfusion (year)? _____
- ☐ CAD (Coronary Artery Disease)
- ☐ Cancer (type)? _____
- ☐ CHF (Heart Failure)
- ☐ Cirrhosis
- ☐ Colon Cancer
- ☐ Colon Polyps
- ☐ COPD
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes I ☐ II ☐
- ☐ Diverticulitis
- ☐ Epilepsy
- ☐ Esophageal Stricture
- ☐ Fatty Liver
- ☐ Fecal Incontinence
- ☐ GERD (Acid Reflux)
- ☐ Hepatitis, B ☐ or C ☐
- ☐ High Blood Pressure
- ☐ Pulmonary Hypertension
- ☐ High Cholesterol
- ☐ IBS
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Aortic Stenosis
- ☐ Migraine Headaches
- ☐ MRSA (Drug Resistant Staph)
- ☐ Multiple Sclerosis
- ☐ Myasthenia Gravis
- ☐ Pancreatic Disease
- ☐ Parkinson's Disease
- ☐ Peripheral Neuropathy
- ☐ Psychiatric Disorders
- ☐ Sleep Apnea with C-pap (level)? ____
- ☐ Stroke
- ☐ Thyroid Disorder
- ☐ Ulcerative Colitis
- ☐ Ulcers
- ☐ Other Conditions: _____
  _____

Medications: It is important for your provider to know all of the medications you are taking (including supplements and over the counter medications) please bring a complete list with correct spelling, dosages and directions to all of your doctor's appointments.

Current Medications	Dose (mg, ml, mcg)	Directions

Marital Status: □ Married □ Single □ Widowed □ Divorced

Security Question: _____ **(City you were born in)**

Race of Patient: □ American Indian/Alaska Native □ Asian □ Black/African American □ Native Hawaiian □ Other Race □ Other/Multi □ White **Ethnicity of Patient:** □ Hispanic or Latino □ Not Hispanic or Latino

Employer: _____ SS# _____