PEDIATRIC PATIENT INFORMATION

PATIENT

First Name (as appears on insurance card)	Middle Name	Last Name	(Jr, III, IV...)

Preferred Name	Age	Date of Birth	Sex: ☐ M ☐ F ☐ ____	Social Security Number

Street Address	City	State	Zip Code
Mailing Address (if different) or **P.O. Box**	City	State	Zip Code

Cell Phone ☐ *preferred*	Home Phone ☐ *preferred*	Primary E-mail address

Race: ☐ White ☐ Asian ☐ Native American or Alaska Native ☐ Black or African American ☐ Unknown ☐ ____________

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Preferred Language (if not English): | **Do you need an interpreter?** ☐ Yes ☐ No

MOTHER ☐ Guarantor/ Person Financially Responsible ☐ Mother's HOME address SAME AS PATIENT

Name	Social Security Number	Street Address	City	State	Zip Code
Employer	Occupation	Employer Street Address	City	State	Zip Code
Cell Phone ☐ *preferred*	Home Phone ☐ *preferred*	Work Phone	Primary E-mail address		

FATHER ☐ Guarantor/ Person Financially Responsible ☐ Father's HOME address SAME AS PATIENT

Name	Social Security Number	Street Address	City	State	Zip Code
Employer	Occupation	Employer Street Address	City	State	Zip Code
Cell Phone ☐ *preferred*	Home Phone ☐ *preferred*	Work Phone	Primary E-mail address		

LEGAL GUARDIAN ☐ Guarantor/ Person Financially Responsible ☐ Legal Guardian's HOME address SAME AS PATIENT

Name	Social Security Number	Street Address	City	State	Zip Code
Employer	Occupation	Employer Street Address	City	State	Zip Code
Cell Phone ☐ *preferred*	Home Phone ☐ *preferred*	Work Phone	Primary E-mail address		

EMERGENCY CONTACT (someone not living with the patient)

Name	Relationship	Street Address, City, State, Zip	Primary Phone ☐ Cell ☐ Home ☐ Work

Primary Care Provider (PCP): | **Referring Provider** (if different from PCP):

INSURANCE *Complete this section ONLY if you do not have insurance card(s) with you

PRIMARY Insurance Provider	Insurance Company: Street Address, City, State, Zip	Group NAME	Group NUMBER
Policy Holder Name (as appears on insurance card)	Date of Birth	Relationship to patient	Policy Number
SECONDARY Insurance Provider	Insurance Company: Street Address, City, State, Zip	Group NAME	Group NUMBER
Policy Holder Name (as appears on insurance card)	Date of Birth	Relationship to patient	Policy Number

We will ask you to update this information every 12 months

Please make us aware if there are changes prior to your annual update

. General Business

CLINIC – PHYSICIAN – PATIENT ARBITRATION AGREEMENT

______________________________("Patient"), engages Gastrointestinal Associates and Endoscopy Center or employee thereof, and each Physician that renders medical care and services to perform services in conjunction with Patient's medical care. For and in partial consideration of the rendition of any and all present and future medical care and services, Patient agrees that in the event of any dispute, claim or controversy arising out of or relating to the performance of medical services, including but not limited to, patient fees, informed consent, negligence or medical malpractice, between Patient (whether a minor or an adult) or the heirs-at-law or personal representative of Patient, as the case may be, and the Gastrointestinal Associates and Endoscopy Center and each Physician individually, where the claim or the amount in controversy exceeds $5,000, such dispute or controversy shall be submitted to JAMS (Judicial Arbitration and Mediation Services, Inc.), or it successor, on an arbitration form for final and binding arbitration. All claims for unliquidated damages shall be deemed claims for in excess of $5,000.

Either party may initiate arbitration of any matter subject to arbitration by filing a written demand for arbitration at any time. Patient shall be entitled to an in-person hearing in his or her county in accordance with the Federal Arbitration Act. The arbitration shall be administered by JAMS pursuant to its Comprehensive Arbitration Rules and Procedures and Minimum Standards of Procedural Fairness, and all parties agree to be bound by the arbitrator's decision. Any decision by the arbitrator(s) shall be accompanied by a reasoned opinion. Judgment may be entered on the arbitrator's award, if any, by any court having jurisdiction of the subject matter.

All parties agree that their relationship affects interstate commerce and that this Agreement shall be governed by the Federal Arbitration Act, and, if not, by Mississippi law. The party requesting arbitration shall bear all costs of the arbitration, except the Patient is not required to pay any more than $125.00, with Gastrointestinal Associates and Endoscopy Center bearing the other arbitration costs.

This Agreement may be rescinded by written notice by either party within fifteen (15) days of signature. However, any claim or dispute related to medical services rendered after execution of this Agreement and prior to the date of such written notice of rescission shall be subject to the terms of this Agreement. Written notice of such rescission may be given by a guardian or conservator of Patient if Patient is a minor or incapacitated. If any portion of this Agreement is found unenforceable, that portion shall be stricken and the remainder of this Agreement fully enforced. If a court rules that the dispute must be litigated and not arbitrated, Patient agrees the suit will be heard in the county where services are rendered.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY CLAIM OF NEGLIGENCE OR MEDICAL MALPRACTICE DECIDED BY NEUTRAL BINDING ARBITRATION AND YOU ARE GIVING UP YOUR STATUTORY AND CONSTITUTIONAL RIGHT TO A JURY OR COURT TRIAL.

If a parent or guardian has signed on behalf of their minor child or ward, such parent or guardian hereby attests that he or she has full legal authority to execute this Arbitration Agreement on behalf of said child or ward. Furthermore, said parent or guardian hereby agrees to indemnify and hold harmless the Clinic from any claim, demand or loss which may occur in the event said parent or guardian does not, in fact, have such legal authority.

A photo static or electronic copy of this authorization shall be considered as effective and as valid as the original.

SIGNATURE OF PATIENT/GUARDIAN

By: ______________________________ Date: ______________

For Office Use Only

Witness Signature: ______________________________ Date: ______________

S/Forms/Arbitration

Rev. 04/16/2019

DIGESTIVE HEALTH CENTER, PA

Patient Interview Form
Pediatrics

20171121

Patient Information

Name: ____________________ **Date of Birth:** ____________________

Reason for visit: ____

Ethnicity: _____Hispanic or Latino _____Not Hispanic or Latino _____ Patient declines to specify

Race: _____White _____ Black or African American _____Asian _____ Native American or Alaska Native

_____Unknown _____Patient declines to specify

Sex: _____ Male _____Female

Allergies **NOTE: Include reaction for each**

_____ No known allergies _____ No known drug allergies

_____ Penicillins _____ Morphine _____ Demerol ___ Latex

_____ Soy _____ IV contrast _____ Codeine Sulphate ___ Tape

_____ Dilaudid _____ Milk _____ Seafood ___ Eggs

_____ Sulpha (Sulfonamides) _____ Other ____________________

Allergic Reaction(s) ____

Current Medications *(Please list pharmacy even if you are not currently taking any medications)*

_____ None **Pharmacy:** ____________________ *(Walgreens, Rite-Aid, etc.)* **Location:** ____________________ *(Flowood, Madison, State St., etc.)*

I consent to obtaining a history of my medications purchased at pharmacies: ◯Yes ◯ No

Name	Strength	How taken? / Frequency?

◯ I needed more space and wrote on the back of this page

Immunizations

_____ None   _____ Up to date   _____ Not up to date

Diagnostic Studies / Tests

_____ None

_____ Colonoscopy When:	_____ EGD When:	_____ EUS When:	_____ ERCP When:	_____ Sigmoidoscopy When:
_____ Capsule Endoscopy When:		_____ PEG tube placement When:		_____ EGD / Dilation When:

Pediatric Medical Conditions

_____ Mouth/Throat Cancer	_____ Esophageal Cancer	_____ Stomach Cancer	_____ Pancreatic Cancer
_____ Blood Cancer (e.g. Leukemia)	_____ Uterine Cancer	_____ Ovarian Cancer	_____ Skin Cancer
_____ Breast Cancer	_____ Lung Cancer	_____ Colon Cancer	_____ Prostate Cancer
_____ ADD / Hyperactivity	_____ Alcohol Problems	_____ Anemia	_____ Anxiety Disorder
_____ Arthritis	_____ Asthma	_____ Autism	_____ Bipolar Disorder
_____ Birth Defects	_____ Bleeding Problems	_____ Blindness	_____ Blood Transfusion
_____ Cancer	_____ Cataracts	_____ Celiac Disease	_____ Colitis
_____ Congenital Heart Condition	_____ Constipation – Chronic	_____ Crohn's Disease	_____ Cystic Fibrosis
_____ Depression	_____ Diabetes	_____ Eating Disorder	_____ Gallbladder Disease
_____ Heart Murmur	_____ Hepatitis	_____ High Blood Pressure	_____ Irritable Bowel Syndrome
_____ Jaundice	_____ Kidney Disease	_____ Liver Disease	_____ Migraine Headaches
_____ Muscle Disease	_____ Pancreatitis	_____ Polyps	_____ Psychiatric Illness
_____ Reflux	_____ Seizures	_____ Sickle Cell Disease	_____ Stroke
_____ Substance Abuse	_____ Thyroid Disorders	_____ Tooth Enamel Problems	_____ Vomiting - Recurrent

_____ Other ____

Pediatric Surgeries

_____ No Pediatric Surgeries

_____ Anesthesia (Problems)   _____ Tonsillectomy   _____ Adenoids

_____ Ear Tubes   _____ Hernia Repair   _____ Tracheotomy

_____ Other ____

Social History

Marital Status

___ Married ___ Single ___ Divorced ___ Widowed

Alcohol

___ None ___ In the past

___ Current Daily ___ Current Weekly ___ Current Monthly ___ Occasional

Tobacco Smoking Status

___ Current Every Day ___ Current Some Day ___ Former Smoker ___ Never

___ Smoker, current status unknown ___ Light tobacco smoker

___ Unknown if ever smoked ___ Heavy tobacco smoker

Drug Use

___ None

___ Uses IV drugs currently ___ Used IV drugs in the past ___ Recreational Drug Use

Review Of Systems

Cardiovascular

None ___	Y	N
Chest pain		
Irregular heart rate/ Heart Murmur		

ENMT

None ___	Y	N
Loose teeth		
Enamel problems		
Nose bleeds		
Throat pain		
Deafness		
Hoarse voice		

Endocrine

None ___	Y	N
Cold Intolerance		

Eyes

None ___	Y	N
Blurred or double vision		
Blindness		

Genitourinary

None ___	Y	N
Frequent urinary infections		
Kidney stones		
Change in urine		

Gastrointestinal

None ___	Y	N
Abdominal pain		
Nausea		
Vomiting		
Diarrhea		
Constipation		
Rectal bleeding		
Heartburn/Indigestion/Reflux		
Difficulty swallowing		
Painful swallowing		
Food/Milk intolorance		
Change in bowel movements		
Bad breath (halitosis)		
Irritable bowel		
Crohn's Disease		
Weight loss		
Poor weight gain		
Colitis / Ucerative colitis		

Hematologic / Lymphatic

None ___	Y	N
Easy bruising		
Anemia		
Clotting problems		
easy bleeding		

Integumentary

None ___	Y	N
Rash		
Bruises		
Jaundice		

Musculoskeletal

None ___	Y	N
Back pain		
Joint pain/redness/swelling		
Neck pain		

Neurological

None ___	Y	N
Convulsions / seizures		
Micraines / headaches		
Weakness		
Dizziness / Passing out		

Respiratory

None ___	Y	N
Chronic cough		
Choking with food		
Hoarseness		

Other Social History

Patient Adopted: _______ Patient attend daycare: _______

Who has legal custody of the patient? ______________________________

Does anyone smoke around the patient? ______________________________

What grade is the patient in school? _______ What school? ______________________________

In the past year, how many days of school did the patient miss due to illness? ______________

Does the patient participate in sports? ______________________________

Is there a history of physical / sexual abuse to the patient? ______________________________

Family changes: ______________________________

Pediatric Hospitalization

Has the patient ever been hospitalized? _______ Reason? ______________________________

____

Pediatric Anesthesia

Has the patient ever had any problems with anesthesia? __________

What reactions and approximate date? ______________________________

Birth History

Patient weight at birth: __________ Patient born full term? __________

Mother's name: ______________________________ Occupation: ______________________________

Father's name: ______________________________ Occupation: ______________________________

Number of siblings: __________

Females only

Has patient starting having periods? _______ Age of patient when she had her first period _______

Date of last period: _______ Problems patient has with period: ______________________________

Does patient use birth control for any reason? _______ Has patient ever been pregnant? _______

Patient under 1 year of age only

How many months was the patient breastfed? _______ What formula was the patient fed? _______

Do you need to change formula? ______ Did the patient have a bowel movement the 1st day of life? _______

Family Medical History

Diagnosis	Mother	Father	Sister	Brother	Grandparent	Other	Unaware
Alcohol problems	☐	☐	☐	☐	☐	☐	☐
Allergies (food / evironmental)	☐	☐	☐	☐	☐	☐	☐
Anemia	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐
Attention deficit disorder / Hyperactivity	☐	☐	☐	☐	☐	☐	☐
Bipolar disorder	☐	☐	☐	☐	☐	☐	☐
Birth defects	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐
Celiac Disease	☐	☐	☐	☐	☐	☐	☐
Coagulation problems	☐	☐	☐	☐	☐	☐	☐
Colitis / Ulcerative colitis	☐	☐	☐	☐	☐	☐	☐
Convulsions (Epilepsy / Seizures)	☐	☐	☐	☐	☐	☐	☐
Crohn's disease	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Easy bruising	☐	☐	☐	☐	☐	☐	☐
Gallbladder disease	☐	☐	☐	☐	☐	☐	☐
Growth / Developmental disorders	☐	☐	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐	☐	☐
Hypertention (High blood pressure)	☐	☐	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐	☐	☐
Liver disease	☐	☐	☐	☐	☐	☐	☐
Migraine headaches	☐	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐	☐
Polyps	☐	☐	☐	☐	☐	☐	☐
Psychiatric illness	☐	☐	☐	☐	☐	☐	☐
Sickle cell disease / Bleeding problems	☐	☐	☐	☐	☐	☐	☐
Stomach problems	☐	☐	☐	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐	☐	☐	☐
Tooth enamel problems	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐

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