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Emerson Health Gastroenterology
310 Baker Ave, suite 175D
Concord, MA 01742
Ph: (978) 287-3835 * Fax: (978) 287-2979

Endoscopy/Colonoscopy: Direct Booking

Dear patient:

Please complete the enclosed patient information forms and send them back. After you send the completed forms back, please allow 1 week for our office to review and call to schedule. If you don't hear form us in this time frame, please call our office. If you have had previous procedures, please document it on the form.

Please be sure to **check with your insurance company regarding coverage** for all appointments. It is helpful to inquire regarding coverage for both **screening and diagnostic colonoscopy procedures.** Although the procedure may be scheduled as a routine preventative screening, it could be become diagnostic if any biopsy taken or diagnosis made at the time of the procedure. After scheduling your appointment, please **call your primary care physician's office to obtain a referral if applicable.**

If you need to cancel or reschedule an appointment, please call us at least 7 days in advance so that we may use that appointment for another patient.

Remember, endoscopic procedures require sedation making it unsafe to drive yourself home. You must plan on a driver being available to take you home approximately three to four hours after the scheduled exam time.

I hope you will find the enclosed information helpful. I wish you well as you go through the process, and look forward to seeing you for your examination. Please do not hesitate to call with any questions or concerns.

Sincerely,

Julio Ayala, MD

John G. Dowd, DO

Andrea Fribush, MD

Tanya Khan, MD

Jennifer Nayor, MD

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

Emerson Health Gastroenterology

Sex ☐ Male ☐ Female
Home Address _____
Phone Numbers Home: _____ Cell: _____ Work: _____
Email address: _____

Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Other
Preferred Language ☐ English ☐ Spanish ☐ Other _____

Height_____ Weight_____

Pharmacy/address/town: _____

Mail order pharmacy: _____

May we discuss your condition with anyone? ( ) yes ( ) no

If yes, with whom? Name: _____Relationship to patient: _____

Other(s): _____

Who may we contact in case of an emergency? _____

Relationship to patient: _____ Phone number: _____

**** IF YOUR INSURANCE REQUIRES REFERRALS YOU ARE RESPONSIBLE FOR OBTAINING THEM PRIOR TO YOUR APPOINTMENT. YOU WILL BE RESPONSIBLE FOR ANY CHARGES INCURRED FOR UNAUTHORIZED CARE. ****

Primary insurance company: _____

Subscriber's name/ relationship: (if not patient): _____ Date of birth: _____

Policy#: _____ Group#: _____

Secondary insurance company: _____

Subscriber's name/ relationship: (if not patient) _____ Date of birth: _____

Policy#: _____ Group#: _____

This information is given for the purpose of establishing an account and medical file with EMERSON HEALTH GASTROENTEROLOGY. It is understood that I shall be responsible for all charges incurred by me (or any minor child as noted above). I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize payment for any insurance claims be made directly to the physician.

Patient Signature: _____ Date: _____

Patient Representative (minor/ unable to sign): _____ Date: _____

Relationship of patient representative to patient: _____

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

Emerson Health Gastroenterology

Reason(s) for your visit ☐ Colonoscopy ☐ Endoscopy ☐ Colonoscopy & Endoscopy

Primary Care Physician _____

1) PAST MEDICAL HISTORY (*check all that apply)*

☐ Anemia	☐ GERD/reflux	☐ High Blood Pressure	☐ Liver Disease
☐ Colon Cancer	☐ Hiatal Hernia	☐ High Cholesterol	☐ HIV/AIDS
☐ Colon Polyps	☐ Ulcers	☐ Irregular Heartbeat	☐ Kidney Disease
☐ Crohn's Disease	☐ Irritable Bowel Syndrome	☐ Heart Disease/Attack	☐ Asthma/COPD/Emphysema
☐ Ulcerative Colitis	☐ Celiac Disease	☐ Diabetes	☐ Obesity
☐ Diverticulitis	☐ Pancreatitis	☐ Stroke	☐ Anxiety/Depression

☐ Other: _____

Previous Gastroenterologist(s) _____

Last Upper Endoscopy: Date: _____ Location: _____

Last Colonoscopy: Date: _____ Location: _____

2) PAST SURGICAL HISTORY *(check all that apply and provide dates)*

☐ Appendectomy	☐ Gallbladder Surgery	☐ Heart Surgery
☐ Colon Surgery	☐ Gastric Surgery	☐ Hysterectomy
☐ Caesarean (C section)	☐ Hernia Surgery	☐ Nissen Fundoplication
☐ Stomach Surgery		

☐ Other: _____

3) MEDICATIONS

List current medications (including herbal) and dosage

_____ _____

_____ _____

_____ _____

_____ _____

If you are on a blood thinner, please state why: _____

4) ALLERGIES ☐ No known medication allergies

List any medication allergies _____

5) FAMILY HISTORY

Does anyone in your family have a history of Colon Cancer, Colon Polyps, Barrett's Esophagus, Esophaeal Cancer, or Stomach Cancer?

☐ YES ☐ NO

If yes, who? _____