4 GASTROENTEROLOGY & HEPATOLOGY OF NORTHWEST OH

NOUFAL JAJEH, M.D., M.S.
BOARD CERTIFIED IN INTERNAL MEDICINE AND GASTROENTEROLOGY

PRACTICE LOCATIONS:

Sidney Office	Lima Office
930 Wapakoneta Ave	524 W Market St Suite, 120
Sidney OH, 45365	Lima Oh, 45802
Ph: 937-492-1575	Ph: 567-289-9039

Fax: 937-949-2707 for both office's

LAST NAME: _____ FIRST NAME: _____ M.I.: _____

DATE OF BIRTH: _____ AGE: _____ Height: _____ Weight: _____

SOCIAL SECURITY NUMBER: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PRIMARY PHONE NUMBER _____

MARITAL STATUS: _____ Spouse/ Significant Other Last Name: _____ First Name: _____

OCCUPATION (Including prior to retirement) & EMPLOYER: _____

WORK PHONE: (Please do not list if you do not want to be contacted at work) _____

REFERRING PHYSICIAN: _____ FAMILY PHYSICIAN: (If different than referring) _____

PHARMACY NAME: _____ Location: _____ Phone: _____

EMERGENCY CONTACT (If spouse, please provide an alternate contact number.): _____

NAME: _____ RELATIONSHIP: _____ PHONE: _____

HEALTH INSURANCE: PLEASE BRING CARD(S) AND VALID I.D. TO YOUR APPOINTMENT-WILL NOT BE SEEN WITH OUT I.D.

PRIMARY INSURANCE NAME: _____ PRIMARY HOLDER: _____

PRIMARY HOLDER'S DOB: _____ ID#: _____

I authorize the Physician and staff to leave messages confirming upcoming appointments with members of family or by voice messages. I hereby authorize the Physician to submit a claim to my insurance carrier of its intermediaries for all covered services rendered by the Physician and authorize and direct my insurance carrier or its intermediaries to issue payment directly to the physician rendering the required services. I authorize Physician and staff to furnish complete information to my insurance carrier or its intermediaries regarding services required. I understand I am financially responsible for all charges not covered by this authorization. I have read and understand the payment information. I also give permission to the Physician to retrieve/use/disclose professional health care information from St. Rita's, Lima Memorial Health System, Wilson Memorial Hospitals and other health care hospitals/facilities, Physicians and Pharmacies for treatment, payment and/or health care operations.

Signature: _____ Date/Time: _____

WHAT PROBLEMS BROUGHT YOU IN TODAY? _____

HAVE YOU HAD SIGNIFICANT WEIGHT GAIN / LOSS IN THE PAST 6 MONTHS? _____

PLEASE CIRCLE BELOW ANY ACTIVE PROBLEMS AND UNDERLINE PROBLEMS YOU HAVE BEEN TREATED FOR IN THE PAST:

General: Fever, chills, weight loss, night sweats

Eyes: Cataracts, double vision, glaucoma, pain on exposure to light, loss of vision, macular degeneration.

Ear, Nose, Throat: Hearing loss, sinus infection, nasal polyps, hoarseness, nose bleeds.

Cardiovascular: High blood pressure, high cholesterol or triglyceride, heart disease, heart murmur, angina, chest pains, rheumatic fever,

Respiratory: Pleurisy, TB, coughing up blood, asthma, emphysema, COPD, bronchitis, shortness of breath, chronic cough, sleep apnea.

Gastrointestinal: Difficulty swallowing, heartburn, acid regurgitation, belching, gas, duodenal or gastric ulcer, abdominal pain, liver disease, Jaundice, hepatitis, gallbladder disease, constipation, diarrhea, black stool, blood in stool, change in bowel habits, incontinence (loss of bowel control)

Genitourinary: kidney or bladder infection, blood in urine, kidney stones, nephritis, urinary incontinence, prostate trouble, sexual problems, sexually transmitted disease, extramarital activity, homosexual activity.

Gynecologic: (For Women) abnormal bleeding, irregular periods, painful intercourse, frequent pelvic infections, endometriosis, List date of your last period:_____

Musculoskeletal: Painful or swollen joints, arthritis, bone problems, osteoporosis, osteopenia.

Skin and Breast: Rashes, psoriasis, melanoma, tattoos, breast lumps, breast cancer, skin cancer.

Neurological: Frequent headaches, migraines, epilepsy, seizures, passing out of dizzy spells, numbness or tingling of arms or legs, stroke, abnormal movements.

Emotional: Sexual, physical or emotional abuse, depression, anxiety, excessive nervousness, marital problems, crying spells, suicidal thoughts, in-law problems.

Endocrine: Diabetes, thyroid disease, other gland problems.

Blood: Anemia, bleeding disorder, blood or blood product transfusion.

Allergic/Immunologic: Lupus, HIV (AIDS), other collagen vascular disease, autoimmune disease or immune deficiency.

Cancer: Please list any previous cancers: _____

Do you use Tobacco? Circle: Yes OR No How many packs a day? _____How many years have you used Tobacco? _____ Do you use Alcohol? Circle: Yes OR No How much and how often: _____ Do you use street drugs/type? _____

Approximate Date of Last: Physical Exam: _____
Colonoscopy: _____
EGD (Upper Scope): _____
GI Series: _____
Any Imagining (for Ex: MRI/CT/Ultrasound) _____

Do you have a history of heart valve problems or need antibiotics before procedures? _____
Do you have a history of allergy or reactions to X-Ray dye or Iodine? _____
Are you sensitive or allergic to latex? _____

ALLERGIES: _____

List chronologically all operations and all hospitalizations please

Approx Date	Operation and/or Diagnosis	Hospital	Physician

PLEASE BRING CURRENT MEDICATIONS OR A LIST OF CURRENT MEDICATIONS WITH YOU INCLUDING DOSAGES, Please include Motrin, Advil, Aleve, or all other "pain" meds, herbal medications and supplements, vitamins, laxatives, antacids and birth control pills.

Medication	Dosage / Strength

PLEASE LIST ALL CURRENT PHYSICIANS

Physician Name	What are they treating you for?

FAMILY HISTORY

	Age	State of Health and Diagnosis	Age at Death and Cause
Father			
Mother			
Brother or Sister			
Brother or Sister			
Father's Father			
Father's Mother			
Mother's Father			
Mother's Mother			
Spouse			
Son or Daughter			

Does anyone in your family have history of colon polyps? _____

Does anyone in your family have history of colon cancer? _____

If yes, please list how they are related: _____

What age were they diagnosed? _____

Does anyone in your family have a history of cancer other than colon? _____

If yes, please list how they are related and what type of cancer? _____

What age were they diagnosed? _____

HIPAA PRIVACY AUTHORIZATION FORM

I, _____, hereby authorize Gastroenterology & Hepatology of Northwest OH to release information to the following friends and family members regarding my health care.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

☐ **Do not discuss/release any of my health care information to anyone but myself.**

_____ _____

Signature of patient or patient's representative *Date/Time*

Gastroenterology and Hepatology of Northwest Ohio

In these times of constant changes of health coverage, much confusion can arise in the area of insurance claims and payments. We have tried to lessen some of the frustration by providing the following information:

Our office will be happy to pre-certify outpatient procedures; however, you are responsible for checking with your insurance company regarding coverage and benefits. If you are scheduled for screening or preventative services, PLEASE VERIFY WITH YOUR INSURANCE CARRIER THAT SCREENING OR PREVENTATIVE SERVICES ARE A COVERED BENEFIT UNDER YOUR PLAN. Some insurance companies may not cover these types of services.

PAYMENTS: We accept cash, VISA/MasterCard, or check (please make payable to: Gastroenterology and

Hepatology of Northwest Ohio). There may be an additional charge if hemoccult or anoscopy are performed. You are responsible for timely payment of your account. We reserve the right to reschedule or deny a future appointment on delinquent accounts.

If your insurance card has any of the following: PCP, Primary Physician, Managed Care, or HMO, you may need an authorization from your family doctor before you can be seen. If you find the above letters or wording on your card, please call your family physician to be sure an authorization has been issued allowing you to be seen by one of our doctors.

SELF PAY: If you have no insurance, we require a $50.00 payment on the date of your visit. A payment plan will be established the date of your visit to ensure timely payment on the rest of your balance.

MEDICARE: We do accept assignment on Medicare. We file the Medicare claim; the payment comes to us; we take any necessary write-offs. Medicare patients are responsible for the 20% balance after Medicare has processed charges and any deductibles which have been applied. If you have supplement insurance we will file the claim if Medicare doesn't automatically.

MEDICAID: We do accept Medicaid patients; however, you must have your card with you at each visit. PLEASE VERIFY WE ARE IN-NETWORK WITH THE NEW MANAGED CARE PLANS OR YOUR VISIT WILL NOT BE COVERED.

ALL INSURANCE: We will be happy to file your office visit charges to your insurance; however, we ask that any co-pay, deductibles, or uncovered services be paid at the time of visit. All services which we provide at the hospitals are filed to your insurance company. Follow up visits are billed separately, they are not included in any other service provided.

WORKER'S COMPENSATION: We do accept Worker's Compensation patients but would like to advise that our diagnosis codes (gastroenterology) are many times not allowed by Workers' Compensation. If you feel your visits with us are due to a work-related problem, please check with the caseworker who is handling your claims to be sure your services will be covered.

Any no show or cancellation without a 24 hour notice will be charged as the following: New Patient: $50.00. Follow up: $25.00. This cannot be billed to the insurance company and must be paid before scheduling a new appointment.