GASTROENTEROLOGY ASSOCIATES

10500 SOUTH CICERO
OAK LAWN, ILLINOIS 60453
TELEPHONE (708) 424 -1202

18210 LAGRANGE ROAD SUITE 201
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TALAL SUNBULLI, M.D. GASTROENTEROLOGY
MICHAEL D'ASTICE, M.D. GASTROENTEROLOGY
HARETH RADDAWI, M.D. GASTROENTEROLOGY
ROGELIO SILVA M.D. GASTROENTEROLOGY

Today's Date _____ Male or Female

Name:_____**Maiden**_____

Address:_____

City:_____ **State**: _____ **Zip**: _____

Home( ) _____ **Work:** ( )_____**Cell Phone**( )_____
May we leave a message on your answering machine? Yes or No
******** No specific personal health information will be left on machine*******

RACE_____

LANGUAGE _____**SPOKEN** yes or no **WRITTEN** yes or no

EMAIL_____

Age: ____Date of Birth : _____ Social Security # : _____-_____-_____

Marital Status: Married Single Divorced Separated Widow/Widower (Circle)

Primary Physician: _____ Phone Number:_____

Referring Physician: _____ Phone Number: _____

Pharmacy Name & Location:_____( )_____

Employer of Insurance Holder:_____Relationship_____

Employer Address:_____

City:_____State:_____ Zip: _____

Patient's Occupation:_____

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Today's Date: _____

Name:_____**Birth Date**: _____

Current Medical Problem:

___Loss of Appetite ___Difficulty Swallowing ____ Change in Bowel Habits ___Gall Bladder Trouble
___Nausea/Vomiting __ Abdominal Pain ____Constipation ___Crohns/Colitis
___Heartburn ___ Hernia _____Diarrhea _____ Jaundice/Hepatitis
____Peptic Ulcer ___Hemorrhoids _____ Bloody/Tarry Stool

Past Medical History:

_____None _____Cardiac _____Kidney Disease _____HIV _____Diabetes
_____Stroke _____Liver Disease _____Drug/Alcohol Abuse _____Sickle Cell
_____Hypertension _____Tobacco Use _____Asthma/COPD _____Seizures _____type
_____Other Cancer_____Site of Cancer_____

Family history of Cancer:
Relationship to patient_____**Site of Cancer** _____

Hospitalization: Type of Surgery Month/Year Hospital

_____

_____

_____

Allergies to Medicine_____

Current Medication: Doses Frequency

_____

_____

_____

_____

_____

GASTROENTEROLOGY ASSOCIATES

□ I have received information regarding the providers of care in this organization, a copy of the Patient's Bill of Rights and Responsibilities, information regarding the grievance process and information regarding the infection control processes of this organization and I understand all the information I have received.

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We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number. The signature below acknowledges my understanding of all the information that I received.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____

Signature_____Date_____

Physician Assignment of Benefits

I hereby authorize GI ASSOCIATES to release any information acquired in the course of my examination or treatment necessary to process insurance claims.

I assign any benefits payable from my insurance carrier to GI ASSOCIATES for services rendered. I understand that I am responsible for any amount not covered by my insurance.

_____ Date:_____

Signature of insured or authorized person