Borland-Groover Clinic

PATIENT GENERATED MEDICAL HISTORY

Place Sticker Here

Name: _____ DOB:_____ Email: _____

Primary Care Physician: _____ Referring: _____

Pharmacy: _____ Pharmacy Phone #: _____

Directions: Please circle any of the following you have personally had during your life:

YOUR PAST MEDICAL HISTORY:

Asthma
COPD Emphysema
Blood Transfusion Date: _____
Cancer:

Breast Cancer **Lung Cancer**
Colon Cancer **Pancreatic Cancer**
Esophageal Cancer **Prostate Cancer**
Kidney Cancer **Stomach Cancer**
Liver Cancer
Other Cancer _____

Congestive Heart Failure
Coronary Artery Disease
Crohns Disease **Ulcerative Colitis**
Diabetes Mellitus: Type 1 Type 2
Gallstones
GERD
High Blood Pressure
Irritable Bowel Syndrome
Liver Disease
Pancreatitis
Peptic Ulcer Disease
Polyps
Sleep Apnea CPAP machine Y / N
Other _____

ALLERGY **REACTION**

❑ No known allergies

_____ _____
_____ _____
_____ _____
_____ _____

YOUR PAST SURGICAL HISTORY:

	Date
Appendectomy	_____
Artificial Heart Valve	_____
Artificial Joint (specify_____)	_____
Bowel Obstruction	_____
Bowel (repair/resection)	_____
CABG/Heart Bypass Vessels _____	_____
Gallbladder removal	_____
Gastric Bypass	_____
Neck Artery/Vascular Surgery	_____
Pacemaker	_____
Pancreatic Surgery	_____
Surgery for Reflux/Hiatal Hernia	_____
Surgery for Ulcers	_____
Vasectomy	_____
Other _____	_____

MEDICAL PROBLEMS LIST / REASON FOR VISIT

_____
_____
_____

YOUR SOCIAL HISTORY:

Occupation_____Working / Retired

Tobacco Status: ❑ Former ❑ Never ❑ Current

Type:_____ ❑ E-Cigs Qty/day_____

 # Yrs_____Age started_____ Stopped_____

Alcohol: Y/N Drinks/Day_____Social _____

Former_____Yr. Stopped_____

Recreational Drug use: Y / N Type: _____

Marital Status: M S D W L

Children #: Y/N boys:_____ girls: _____

Directions: Please circle any of the following that exists in your family.

YOUR FAMILY HISTORY:

❑ Adopted

TYPE	RELATIONSHIP	Paternal/ Maternal	AGE
Cancer, Breast	_____	**P/M**	_____
Cancer, Colon	_____	**P/M**	_____
Cancer, Ovary	_____	**P/M**	_____
Cancer, Uterus	_____	**P/M**	_____
Cancer _____	_____	**P/M**	_____
Colon Polyps	_____	**P/M**	_____
Crohn's Disease	_____	**P/M**	_____
Gallstones	_____	**P/M**	_____
Liver Disease	_____	**P/M**	_____
Pancreatic Dis.	_____	**P/M**	_____
Ulcerative Colitis	_____	**P/M**	_____
Ulcers	_____	**P/M**	_____

AGE

Mother: Alive Y/N If no, cause _____ _____

Father: Alive Y/N If no, cause _____ _____

Sister: Alive Y/N If no, cause _____ _____

Brother: Alive Y/N If no, cause_____ _____

Other Diseases That Run In The Family:_____

_____
_____

Last Influenza Vaccine: _____
Last Pneumonia Vaccine: _____

Borland-Groover Clinic

MEDICATION LOG

NAME: _____ DOB: _____

DIRECTIONS: Please list any over the counter or prescribed medications you currently take.

Drug Name	Dosage	Start Date	Why do you take the medicine?
☐ See Attached Medication List			

Borland-Groover Clinic

GI REVIEW OF SYSTEMS - MALE

NAME: _____ DOB: _____

Directions: Have you had any of the following in the last three months?

NO	YES	
❒	❒	chills
❒	❒	fever
❒	❒	lack of energy
❒	❒	weight loss

NO	YES	
❒	❒	nasal congestion
❒	❒	sinus infection
❒	❒	sore throat

NO	YES	
❒	❒	short of breath
❒	❒	frequent cough
❒	❒	wheezing

NO	YES	
❒	❒	chest pain
❒	❒	extremity swelling
❒	❒	palpitations

NO	YES	
❒	❒	abdominal pain
❒	❒	change in bowel habits
❒	❒	constipation
❒	❒	diarrhea
❒	❒	difficulty swallowing
❒	❒	heartburn
❒	❒	vomiting blood
❒	❒	blood in stool
❒	❒	loss of appetite
❒	❒	black stool
❒	❒	nausea
❒	❒	reflux
❒	❒	vomiting

NO	YES	
❒	❒	painful urination
❒	❒	blood in urine
❒	❒	urinary frequency
❒	❒	urinary incontinence

NO	YES	
❒	❒	penile discharge

NO	YES	
❒	❒	cold intolerance
❒	❒	excessive thirst
❒	❒	heat intolerance

NO	YES	
❒	❒	headache
❒	❒	numbness
❒	❒	tremors
❒	❒	sensation of room spinning

NO	YES	
❒	❒	anxiety
❒	❒	increased stress

NO	YES	
❒	❒	contact allergy
❒	❒	hives
❒	❒	itching
❒	❒	rash

NO	YES	
❒	❒	back pain
❒	❒	muscle pain
❒	❒	joint pain

NO	YES	
❒	❒	easy bleeding
❒	❒	easy bruising
❒	❒	enlarged lymph glands

NO	YES	
❒	❒	asthma
❒	❒	food allergies
❒	❒	altered/weakened immune system
❒	❒	seasonal allergies

NO	YES	
❒	❒	bloating
❒	❒	uncontrolled bowel movements
❒	❒	gas
❒	❒	hemorrhoids
❒	❒	yellow skin
❒	❒	painful swallowing
❒	❒	rectal bleeding

Borland-Groover Clinic Financial Policy

It is the policy of Borland-Groover Clinic to provide our patients with access to the highest quality gastroenterological care available. In order for us to do so, we must ensure that we are able to meet our operational expenses. We ask that you read, understand, and sign our Financial Policy prior to receiving treatment.

PAYMENT AT TIME OF SERVICE

As a courtesy, we will bill your insurance for all services; however, we ask that you pay any portion of your costs not covered by your insurance due to deductibles, co-insurances or co-payments on the day of service. Billing for these items is not only costly, but our statements often go unpaid. This results in increased costs to both you and our other patients.

MEDICAL FORMS

Patient request for physician/clinical staff to complete employer medical related forms/letters will be charged a fee of $25, per form. Fee must be paid by cash/credit card at time of request.

SUBMISSION OF CLAIMS

Your health insurance plan is a contract between you and your insurer. Although we file insurance claims as a courtesy to you, charges not paid by your insurance company are your responsibility. Working together, we can resolve most insurance issues in a mutually acceptable manner; nevertheless, it is the patient's responsibility to understand his or her policy limitations. In the event your health insurance determines that they will not cover a service that you have received, you will be responsible for payment.

OUTSTANDING BALANCES

We urge you to keep your account current to avoid any misunderstandings with our office. When an account balance becomes more than 45 days past due, it will be referred to an outside collection agency. At that time, any additional fees incurred on the account will be the responsibility of the patient. If you need to make special payment arrangements, it is your responsibility to contact one of our financial counselors before your account is sent to an agency. Minimum monthly payment arrangements may be made for no less than $50.00 unless approved by the Director of Finance. As a last resort, patients who fail to make payments could be terminated from the practice.

PAYMENT OPTIONS

You will receive monthly statements. The amount shown in the "PLEASE PAY THIS AMOUNT" box is your financial obligation. It is due and payable upon receipt. For your convenience, we accept payment in the form of cash or check and from Visa, MasterCard, American Express and Discover. Payments may be made on our website at www.borland-groover.com, called in at (904) 398-2183, or mailed to 4800 Belfort Road, Jacksonville, Florida 32256.

CHARITY CARE

Our financial counselors are available to assist our patients in applying to receive charity care. This may be available for those who earn up to 200% of Federal Poverty Guidelines.

RETURN CHECK, NSF, CLOSED ACCOUNTS

Payments made to Borland Groover Clinic that are not honored by the bank will incur a return check fee of $50.00. If failure to pay check and fee within 15 days of receiving return check, notice from Borland Groover Clinic account will be turned over to the State Attorney's office.

Patient Name Patient Signature Date

By signing above, you agree to all the terms and conditions contained herein.

Borland-Groover Clinic
Acknowledgement of Receipt of Notice & PHI Disclosure Authorization

Patient's Full Name **Patient's Date of Birth**

1. I hereby authorize Borland-Groover Clinic to use or disclose protected health information (PHI) about me to the following person(s). Please write "N/A" in any of the 3 fields below if not populated with the name of a person:

	Authorized Individual #1	**Authorized Individual #2**	**Authorized Individual #3**
Name			
Address			
City, State Zip			
Phone Number			

2. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
3. This authorization expires upon written notice from me, and may be revoked at any time. Revocation must be in writing and submitted to the following address: Privacy Officer, 4800 Belfort Rd, Jacksonville, FL 32256.
4. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
5. ***NOTICE***: I acknowledge that I have had the opportunity to review a copy of BGC's Notice of Privacy Practices ("Notice"). I understand that I am responsible to read this Notice and notify BGC, in writing, of any request for restrictions in the use or disclosure of my PHI. I understand BGC has the right to revise this Notice at any time and will post a copy of the current Notice in the office in a visible location at all times and on their website at www.borlandgroover.com. BGC will provide me with a copy of its most recent Notice upon my request.
6. I understand the most recent version of this form replaces any previous versions on file in my BGC health record. Previous versions will be voided and PHI release will be based on the current version of this authorization.
7. Borland-Groover Clinic does not discriminate against any person on the basis of race, color, national origin, disability, or age (and any other bases you wish to include) in admission, treatment, or participation in its programs, services and activities, or in employment, or on the basis of sex in its health programs and activities. For further information about this policy, contact: Chad Bailey, CAO, 904-398-3262 or write to: 4800 Belfort Road, Jacksonville, Florida 32256.

_____ _____
Signature of Patient — Date of Patient Signature

OR

_____ _____ _____
Signature of Patient's Representative — Date of Representative's Signature — Description of Authority to Act for the Patient

A copy of this completed, signed and dated form must be given to the Individual or other signator.