**PATIENT GENERATED MEDICAL HISTORY**

**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
- Crohn's 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:**

- 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: ________

**YOUR FAMILY HISTORY:**

- Adopted __________

<table>
<thead>
<tr>
<th>TYPE</th>
<th>RELATIONSHIP</th>
<th>Paternal/ Maternal</th>
<th>AGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer, Breast</td>
<td>P/M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer, Colon</td>
<td>P/M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer, Ovary</td>
<td>P/M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer, Uterus</td>
<td>P/M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colon Polyps</td>
<td>P/M</td>
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<td>P/M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ulcers</td>
<td>P/M</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- 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: __________

BGC-464 Rev. 04/16
## MEDICATION LOG

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

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosage</th>
<th>Start Date</th>
<th>Why do you take the medicine?</th>
</tr>
</thead>
<tbody>
<tr>
<td>See Attached Medication List</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NAME:** ___________________  
**DOB:** ___________________
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
☐    ☐ 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.

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.

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Patient Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

*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:

<table>
<thead>
<tr>
<th>Authorized Individual #1</th>
<th>Authorized Individual #2</th>
<th>Authorized Individual #3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name</strong></td>
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<tr>
<td><strong>Address</strong></td>
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<td></td>
<td></td>
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<tr>
<td><strong>City, State Zip</strong></td>
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<tr>
<td><strong>Phone Number</strong></td>
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</tbody>
</table>

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](http://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.

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**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.