GastroCenter Of Michigan

PHYSICIAN: DR. RANA SABBAGH

Patient Information

(First, Middle, Last Name) _____ (Date of Birth) _____

(Address) _____ (City, State, Zip Code) _____

(Email Address) _____ (Social Security Number) _____

(Home Number) check if preferred ☐ (Work Number) check if preferred ☐ (Cell Number) check if preferred ☐

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Gender: ☐ Male ☐ Female
Preferred Language: ☐ English ☐ Other _____
Race: ☐ White ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or other Pacific Islander ☐ Other _____
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Primary Insurance Information

(Name of Insurance Company) _____

(Subscriber's Name) _____ (Date of Birth) _____

(Member ID) _____ (Group) _____ (Relationship to Patient) _____

Secondary Insurance Information

(Name of Insurance Company) _____

(Subscriber's Name) _____ (Date of Birth) _____

(Member ID) _____ (Group) _____ (Relationship to Patient) _____

Referring Physician

(Name) _____

(Address) _____

(City) _____ (State, Zip Code) _____

(Phone) _____

Primary Care Physician

(Name) _____

(Address) _____

(City) _____ (State, Zip Code) _____

(Phone) _____

Patient Employment

(Name) _____

(Position) _____

Emergency Contact

(Name) _____

(Phone Number) _____ (Relation) _____

How did you hear about our clinic?

- ☐ Referring Provider
- ☐ Mailer
- ☐ Insurance Company
- ☐ Newspaper
- ☐ Family member
- ☐ Other
- ☐ Online

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PATIENT NAME: _____ **Date of Birth:** _____ **Date:** _____

Review	YES
Lightheaded/Dizziness	
Nausea/Vomiting	
Headaches	
Upset Stomach with antibiotics	
Excessive Fatigue	
Yeast infections with antibiotics	
Problems with bleeding	
Problems with healing	
Problems with scarring	
Rash	
Vision Changes	

Alerts	
Pregnancy or Planning Pregnancy?	
Currently Breastfeeding?	
Have a Pacemaker?	
Have a Defibrillator?	
Artificial Joints?	
Artificial Heart Valve?	
Allergy to Adhesive?	
Allergy to Lidocaine?	
Allergy to Latex?	
Currently taking Blood Thinners?	

Medical History	Self	Family
Anxiety		
Arthritis		
Artificial Joints		
Asthma		
Breast Cancer		
Cirrhosis		
Colon Cancer		
COPD		
Depression		
Diabetes		
GERD		
Hepatitis A, B, C		
Hernia		
High Blood Pressure		
HIV/AIDS		
High Cholesterol		
Hyperthyroidism		
Hypothyroidism		
Irritable Bowel Syndrome		
Seizures		
Stroke		

Past Surgical History	YES
Mastectomy (Right, Left, Bilateral)	
Lumpectomy (Right, Left, Bilateral)	
Colectomy: Colon Cancer Resection	
Colectomy: Diverticulitis	
Colectomy: Irritable Bowel Disease	
Coronary Artery Bypass	
Gallbladder Removed	
Cesarean	
Joint Replacement, Knee (Right, Left, Bilateral)	
Joint Replacement, Hip (Right, Left, Bilateral)	
Kidney Removed (Right, Left)	
Hysterectomy (Full, Partial)	

Social History	YES
Cigarette Smoking:	
Never Smoked	
Quit: Former Smoker	
Smokes less than daily	
Smokes Daily (5, 10, 15, 20+ Cigarettes a day)	
Hookah Smoking: Daily, Less than Daily	
Drug Use: within the last 12 months	
Never used drugs	
Alcohol Use:	
None	
Less than one drink a day	
1-2 drinks a day	

Circle all that Apply	None
Constitutional – Weight Loss Weight Gain Excessive Thirst Fatigue	
Ears / Eyes – Hearing Loss Vision Loss Vertigo Other	
Nose / Mouth / Throat – Nose Bleeds Hoarseness Tooth or Gum Trouble Mouth Sores	
Lungs – Chronic Cough Shortness of Breath Pneumonia Asthma Emphysema TB	
Stomach – Nausea Vomiting Stomach Pain Ulcers Heartburn	
Bowels – Frequent Diarrhea Frequent Constipation Hemorrhoids	
Urinary Tract – Frequent Burning Urination Difficulty Starting Urination Frequent Urination	
Heart – Chest Pain Palpitations Abnormal Heartbeat Swollen Ankles Murmur	
Psychological Problems – Depression Hallucinations Frequent Anxiety Sleep Disturbances	
Behavior Problems – ADHD ADD Other	

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PATIENT NAME: _____ Date of Birth: _____ Date: _____

MEDICATIONS

ALLERGIES

PHARMACY INFORMATION
NAME
ADDRESS
CITY/STATE
PHONE

GastroCenter Of Michigan

Patient Financial Responsibility

Thank you for choosing The GastroCenter of Michigan as your provider for gastroenterology care. We strive to provide the most efficient and patient-friendly care to all our patients. In effort to provide the best care, it is important that you read the financial responsibility form below.

Please inform the front office staff if your insurance plan has changed (active/inactive), if you have received a new insurance card, or if you do not have insurance currently.

Copayments and past due balances are due following your visit for that day. **If you do not have insurance or a referral, you will be responsible for the full charged amount of your visit.**

There are certain fees associated with requesting copies of medical records. Please ask the office staff to clarify the cost of medical record request.

CONSENT TO EXAMINATION AND TREATMENT: I understand and voluntarily consent to receive medical and health care services given by the GastroCenter of Michigan and Rana Sabbagh MD. I understand the examination procedures will be explained to me and I authorize the administration of all diagnostic and therapeutic procedures, examinations and treatments considered advisable or necessary in the judgement of the physician. I understand that the examination results will be provided to me with recommendations. No guarantee or assurance has been given by anyone as to the results that may be obtained by such treatments. The responsibility for any follow up examinations to check abnormalities found and treated, lies with me and not with the GastroCenter of Michigan and Rana Sabbagh MD. I hereby release my examiner from all responsibility in connection with the examination. I understand that in order for the doctor to give me the best medical care possible, I must follow instructions and notify the office if I have problems with my medications or treatment.

CANCELLED OR MISSED APPOINTMENTS: We are happy to reschedule any appointment for you. We do request Twenty-four (24) hour notice of cancellation. It is our aim to accommodate you the patient. We have patients eager to use your cancelled appointment time. We reserve the right to charge a cancellation fee of twenty five dollars ($25) for appointments not cancelled 24 hours in advance. We hope you, our values patient, will cooperate in this simple request.

FOR PROCEDURE APPOINTMENTS: We require 48 hour notice for procedure appointments if you need to reschedule or cancel. For procedure appointments not cancelled 48 hours in advance you will be charged a fifty dollar ($50) fee.

NOTICE OF PRIVACY PRACTICES: I acknowledge that I have received a copy of the GastroCenter of Michigan's Notice of Privacy Practices.

PATIENT'S/GUARDIAN'S SIGNATURE DATE

PATIENT'S NAME PRINTED DATE